MAGELLAN HEALTH

QUALITY IMPROVEMENT – CLINICAL / UTILIZATION MANAGEMENT

PROGRAM EVALUATION

FOR

Behavioral Health Division
Louisiana Unit

March 1, 2014-February 28, 2015

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Magellan Health (Magellan) Louisiana Unit conducts an annual evaluation of its Quality Improvement Program to evaluate outcomes; review effectiveness; assess goal achievement; evaluate the deployment of resources; document and trend input from advisory groups, including members, family members and other stakeholders; 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 Unit data from March 1, 2014 through February 28, 2015. In addition, this report assesses progress towards the goals and prioritized objectives set forth in the previous year's Louisiana Unit quality improvement program description, work plan and program evaluation helping to ensure that the spirit of the Louisiana Unit's mission is realized.

The Program Evaluation is an internal practical document used by Magellan in 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 prior year accomplishments identified as a result of this evaluation include:

- Served a total of 168,469 unique members (i.e., unduplicated members with at least one claim received during the time parameter).
- The penetration rate of the total population served was 11.6% (n=1,455,184), which is slightly higher than the rate of 10% in 2013.
- Increased provider network 502.8% from March 1, 2012 to February 28, 2015, with 23.4% growth since March 1, 2014.
- Met goals for all Performance Guarantees for telephone responsiveness, claims administration, clinical, and satisfaction outcomes for all three contract years.
- Answered 139,062 calls with a 19-second average speed of answer (ASA) and a 2.7% abandonment rate, meeting contractual performance guarantee goals for telephonic responsiveness.
- Improved provider satisfaction from 80.2% in contract year one to 87.7% in contract year three.
- Implemented ACT scorecard tied to a pay-for-performance model. The ACT scorecard demonstrated improved outcomes, including a 15.7% decrease in readmissions, 12.7% decrease in admissions per hundred and 10.52% decrease in Average Length of Stay.
- Reduced overall readmission rate by 33.2% from contract year two, with a rate of 7.8%.

- Successfully launched the CSoC program statewide, with the expansion of the remaining four regions in November 2014.
- Served approximately 4,351 individuals in the CSoC program since March 1, 2012.
- Increased adult members served in Substance Use Intensive Outpatient by 43.8%.
- Increased child members served by Home and Community Based services. Utilization for CPST increased 34.6% and PSR increased 40.7% from January 2014 to December 2014.
- High-utilizer rounds intervention consistently shows improved outcomes, most recently resulting in a 62% reduction in bed days for top 50 identified bed- day members in contract year three, quarter four.
- Implemented statewide Independent Assessment/Community Based Care Management (IA/CBCM) program to ensure compliance with the 1915(i) State Plan Amendment.
- Continued partnering 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 prescriber network 512.1% since March 1, 2012, with a 17.8% increase since March 1, 2014.
- Received a total of 777 member referrals from the Bayou Health Plans as a result of the implementation of a standardized referral process focused on improved coordination of care.

Program Focus and Prioritized Objectives for 2015

Based on a review of:

- Progress towards 2014-15 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 Unit for 2015:

Positively influencing Health and Well being, including patient safety-

1. Increase patient quality of care.
2. Advance a resiliency, recovery, and consumer-focused system of person-centered care.

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

3. Achieve better outcomes for behavioral health and improving quality by measuring these outcomes.

Enhancing Service and the Experience of Care-

4. Improve access, quality, and efficiency of behavioral health services for children and youth with specialized behavioral health needs and adults with Serious Mental Illness and Substance Use Disorders, through management of these services by the SMO.
5. Reduce the rate of avoidable hospital stays and readmissions.
6. Implement best, evidence-based and informed practices that are effective and efficient as supported by the data from measuring outcomes, quality, and accountability.

Meeting and exceeding contractual, regulatory and accreditation requirements-

7. Maintain the Coordinated System of Care (CSoC) for children/youth and their families/caregivers by utilizing a family and youth-driven practice model, providing wraparound facilitation by child and family teams, which also utilize family and youth supports, and overall management of these services by the SMO.
8. Maintain URAC accreditation through the end of the contract term.

To accomplish these goals, the following prioritized objectives were determined by the Louisiana Unit:

1. Conduct peer reviews to assess the quality and appropriateness of care furnished to members.
2. Conduct a member survey that assesses member satisfaction with the quality, availability, and accessibility of care and experience with his/her providers and the SMO.
3. Solicit feedback and recommendations from key stakeholders, subcontractors, members, members' families/caregivers and providers through the Quality Improvement Committee structure and grievance and appeals monitoring, and using the feedback and recommendations to improve performance.
4. Improve the ability to report CSoC outcome measures by shifting from paper-based to electronic submission of CANS.
5. Monitor submission of Plan of Care documents for minor and adult SMI population to ensure it adequately addresses the member's needs and identifies the appropriate level of services.
6. Detect and address under-and-over utilization of services through use of control charts.
7. Maintain enhanced monitoring of hospital stays and readmissions of adult and minor SMI population through quarterly Assertive Community Treatment (ACT) and Wraparound Agency (WAA) Scorecards and increase provider accountability through continuation of pay-for-performance model with ACT providers.
8. Monitor sub-contracted provider activities to ensure compliance with federal and state laws, regulations, waiver and Medicaid State Plan requirements, the SMO RFP/contract, and all other quality management requirements.
9. Establish a fidelity monitoring system to verify providers' adherence to evidence-based and evidence-informed practices ensuring the core elements of the intervention are maintained.

10. Actively collaborate and participate in the transition plan as directed by the State.

ACKNOWLEDGMENT AND APPROVAL

The 2014-15 Quality Improvement and Utilization Management Program Evaluation was prepared by the Louisiana Unit and reviewed and approved by the Quality Improvement Committee during its meeting on DATE 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	

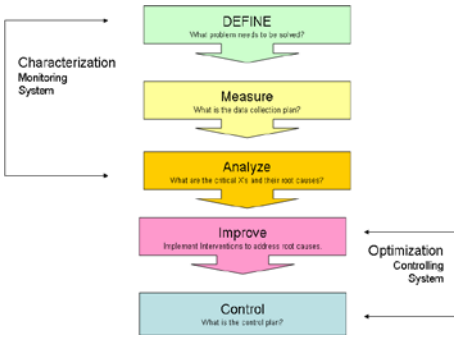
I. OVERVIEW

The Magellan Healthcare (Magellan) Louisiana Unit 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 Louisiana Unit 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 Louisiana Unit's quality program is comprehensive and covers the following product lines: Behavioral Health Care Management and Recovery and Resiliency Care Management. In addition, the Louisiana Unit manages the Coordinated System of Care programs for eligible members. The Louisiana Unit also managed components of the Permanent Supportive Housing Program through end of contract year three.

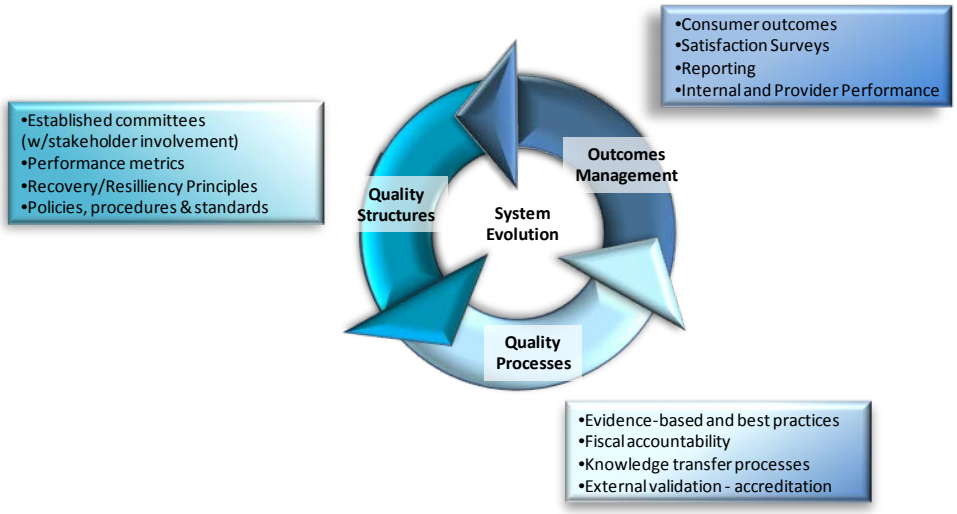
The scope of the Quality Improvement (QI) program includes the objective and systematic monitoring of the quality of behavioral health and related recovery and resiliency services provided to the members of the customer organizations served by Magellan. The Louisiana Unit QI Program is the direct responsibility of the Louisiana Unit 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 Louisiana Unit 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 Louisiana Unit QI program utilizes a Six Sigma (Define, Measure, Analyze, Improve, Control (DMAIC)) process to ensure 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 Louisiana Unit QI committees oversee this process and a spectrum of measures and activities that are described in the Louisiana Unit Quality Improvement Program Description and evaluated in this document.



QI committee oversight is a crucial component of the Louisiana Unit 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 Louisiana Unit Quality Improvement Program Description for further description of the quality improvement committees and processes in place at the Louisiana Unit.



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 to determine 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 Louisiana Behavioral Health Partnership (LBHP) members in order to enable the Louisiana Unit 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 Louisiana Unit 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 Louisiana Unit to make informed and effective improvements to ongoing QI activities. The assessment evaluates member demographics, provider network demographics, and cultural competency program.

A. Member Demographic

This section provides a demographic analysis of the members served by the Louisiana Unit. It serves as a mechanism to better understand Louisiana Unit members' characteristics to ensure services are in place to adequately meet the needs of the members. The primary data source for member demographics is the Medicaid eligibility feed; however, multiple data sources are utilized to ensure the most complete data set are available, including Caps Adjudication Payment System (CAPS), Integrated Product (IP), and Clinical Advisor (CA) feeds. The time parameter is calendar year 2014, and comparisons are given for calendar years 2013 and 2014. Analysis focuses on the Medicaid eligible population as it represents a majority of the membership; although, non-Medicaid and unknown populations are presented as well for reference. Please see **Section VIII Evaluation of Over/Under Utilization of Services** for a more detailed analysis of utilization by level of care. The following list of the demographic variables is analyzed within this section:

- Population
- Age
- Gender
- Veteran Status
- Regions
- Top mental health diagnoses for age groups
- Race/Ethnicity

Population

This number accounts for all populations served under the LBHP, including Medicaid and non-Medicaid populations. There was 0.6% growth in the number of eligible members from 2013 to 2014. The prevalence rates (the percentage of a population) for eligibility from 2013 to 2014 showed minimal changes. The penetration rate is the number of members that received services divided by the number of members eligible. There were no notable changes in the penetration or prevalence rates from 2013 to 2014. The prevalence rates of the populations can be seen in the chart below.

	Calendar Year 2013				Calendar Year 2014			
Medicaid Status	N_Members	Prevalence	N_Members Served	Prevalence	N_Members	Prevalence	N_Members Served	Prevalence
Medicaid	1,190,597	82.34%	118,652	73.44%	1,185,207	81.45%	131,218	77.89%
Non-Medicaid	286,075	19.78%	41,115	25.45%	308,492	21.20%	34,737	20.62%
Unknown	5,090	0.35%	5,090	3.15%	5,688	0.39%	5,688	3.38%
Total	**1,445,985**	**100.00%**	**161,570**	**100.00%**	**1,455,184**	**100.00%**	**168,469**	**100.00%**

Age

Medicaid groups members into two major age categories. The youth category represents members between zero and 21, and the adult category represents members over 21. The penetration rate for Medicaid youth members was 9.4%, or 78,916, served of the 836,342 eligible members. Medicaid adults had a penetration rate of 15.0%, or 52,302, served of the 348,865 eligible members. There were no notable changes in the penetration or prevalence rates from 2013 to 2014. The most age categories were representative of the Medicaid eligible population. The 13-17 and 22-64 age categories showed some elevation in representation in the members served. Although many confounding variables exist that might explain this, Magellan has established interventions, such as Coordinated Systems of Care and Independent Assessors/Community-Based Care Managers, to ensure members in both these age groups with Severe and Persistent Mental Illness and Severe Emotional Disturbance have increased access to services. Please refer to **Section XVII 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 represented a prevalence rate of 4.79% of the members served despite representing a prevalence rate of 24.57% for 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 and vulnerable population. Magellan has partnered with Louisiana State University and Tulane University to provide 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 XVI Evidence- and Best Practice Initiatives.**

		Calendar Year 2013				Calendar Year 2014			
Medicaid Status	Age Group	N_Members	Prevalence	N_Members Served	Prevalence	N_Members	Prevalence	N_Members Served	Prevalence
Medicaid	0 - 5	297,366	24.98%	5,272	4.44%	291,253	24.57%	6,290	4.79%
Medicaid	6 - 12	287,022	24.11%	30,419	25.64%	291,150	24.57%	36,848	28.08%
Medicaid	13 - 17	177,081	14.87%	24,638	20.76%	181,262	15.29%	28,900	22.02%
Medicaid	18 - 21	77,096	6.48%	6,289	5.30%	72,677	6.13%	6,878	5.24%
Medicaid	22 - 64	293,832	24.68%	47,638	40.15%	291,707	24.61%	48,199	36.73%
Medicaid	65+	58,200	4.89%	4,396	3.70%	57,158	4.82%	4,103	3.13%
Medicaid	Total	1,190,597	100.00%	118,652	100.00%	1,185,207	100.00%	131,218	100.00%
Non-Medicaid	0 - 5	2,205	0.77%	52	0.13%	2,941	0.95%	48	0.14%
Non-Medicaid	6 - 12	2,597	0.91%	180	0.44%	2,137	0.69%	142	0.41%
Non-Medicaid	13 - 17	2,907	1.02%	409	0.99%	2,091	0.68%	365	1.05%
Non-Medicaid	18 - 21	27,988	9.78%	2,404	5.85%	30,013	9.73%	1,839	5.29%
Non-Medicaid	22 - 64	223,940	78.28%	36,964	89.90%	241,668	78.34%	31,349	90.25%
Non-Medicaid	65+	26,438	9.24%	1,106	2.69%	29,642	9.61%	994	2.86%
Non-Medicaid	Total	286,075	100.00%	41,115	100.00%	308,492	100.00%	34,737	100.00%
Unknown	Unknown	5,090	100.00%	5,090	100.00%	5,688	100.00%	5,688	100.00%
Unknown	Total	5,090	100.00%	5,090	100.00%	5,688	100.00%	5,688	100.00%
Total	Total	1,445,985		161,570		1,455,184		168,469	

Gender

There were little changes in the prevalence rates between calendar years 2013 and 2014. The female gender represented 52.42% of the Medicaid eligible population, with the male gender representing 47.57%. In 2014, there were slight improvements in the penetration rates for both males and females with 10.2% of eligible female members being served by the LBHP (9.2% in 2013) and 12.1% of eligible males being served (11.0% in 2013). There are no notable opportunities for improvement related to gender at this time.

		Calendar Year 2013				Calendar Year 2014			
Medicaid Status	Gender	N_Members	Prevalence	N_Members Served	Prevalence	N_Members	Prevalence	N_Members Served	Prevalence
Medicaid	Female	675,839	56.76%	62,274	52.48%	671,518	56.66%	68,786	52.42%
Medicaid	Male	514,722	43.23%	56,372	47.51%	513,639	43.34%	62,421	47.57%
Medicaid	Unknown	36	0.00%	6	0.01%	50	0.00%	11	0.01%
Medicaid	Total	1,190,597	100.00%	118,652	100.00%	1,185,207	100.00%	131,218	100.00%
Non-Medicaid	Female	185,299	64.77%	18,050	43.90%	190,481	61.75%	15,295	44.03%
Non-	Male	91,625	32.03%	19,739	48.01%	108,837	35.28%	17,241	49.63%

Medicaid									
Non-Medicaid	**Unknown**	9,151	3.20%	3,326	8.09%	9,174	2.97%	2,201	6.34%
Non-Medicaid	**Total**	286,075	100.00%	41,115	100.00%	308,492	100.00%	34,737	100.00%
Unknown	**Female**	754	14.81%	754	14.81%	1,866	32.81%	1,866	32.81%
Unknown	**Male**	598	11.75%	598	11.75%	2,332	41.00%	2,332	41.00%
Unknown	**Unknown**	3,738	73.44%	3,738	73.44%	1,490	26.20%	1,490	26.20%
Unknown	**Total**	5,090	100.00%	5,090	100.00%	5,688	100.00%	5,688	100.00%
Total	**Total**	1,445,985		161,570		1,455,184		168,469	

Veteran Status

The data for veteran status were not pulled from Medicaid eligibility and therefore depended on self entry to collect data. Because of this, 99.8% of data regarding veteran status were unknown. In order to improve the usability of the data, unknown data were removed to show the prevalence rates for known data. In 2014, a majority of the members served in 2014 were non-veterans (98.93%), which is consistent with 2013. It is believed number of veterans served was low because they access service through other avenues (e.g., Veterans Administration providers).

		Calendar Year 2013		Calendar Year 2014	
Medicaid Status	**Veteran Status**	N_Members Served	Valid Percent	N_Members Served	Valid Percent
Medicaid	**No**	50,061	98.96%	39,765	98.93%
Medicaid	**Yes**	526	1.04%	431	1.07%
Non-Medicaid	**No**	30,299	96.65%	25,004	96.66%
Non-Medicaid	**Yes**	1,051	3.35%	864	3.34%
Unknown	**No**	3,333	97.43%	2,842	97.56%
Unknown	**Yes**	88	2.57%	71	2.44%

Data by Region

Regional data supported that most of the regions were adequately represented in the members served population. There are no identified opportunities for improvement identified at this time.

		Calendar Year 2013				Calendar Year 2014			
Medicaid Status	Region	N_Members	Prevalence	N_Members Served	Prevalence	N_Members	Prevalence	N_Members Served	Prevalence
Medicaid	**Acadiana Human Services District**	156,106	13.11%	12,728	10.73%	156,029	13.16%	14,172	10.80%

Medicaid	**Capital Area Human Services District**	154,837	13.00%	15,386	12.97%	154,960	13.07%	16,821	12.82%
Medicaid	**Central Louisiana Human Services District**	83,048	6.98%	7,382	6.22%	82,788	6.99%	8,552	6.52%
Medicaid	**Florida Parishes Human Service Authority**	126,801	10.65%	13,920	11.73%	127,887	10.79%	15,489	11.80%
Medicaid	**Imperial Calcasieu Human Service Authority**	73,322	6.16%	7,971	6.72%	73,373	6.19%	7,831	5.97%
Medicaid	**Jefferson Parish Human Service Authority**	101,744	8.55%	11,529	9.72%	102,959	8.69%	13,063	9.96%
Medicaid	**Metropolitan Human Service District**	120,504	10.12%	14,339	12.08%	120,892	10.20%	16,304	12.43%
Medicaid	**Northeast Delta Human Services District**	103,760	8.71%	10,877	9.17%	104,759	8.84%	12,499	9.53%
Medicaid	**Northwest Louisiana Human Services District**	142,036	11.93%	12,438	10.48%	144,707	12.21%	13,872	10.57%
Medicaid	**South Central Louisiana Human Service Authority**	100,296	8.42%	10,580	8.92%	99,771	8.42%	11,544	8.80%
Medicaid	**Unknown**	29,179	2.45%	2,507	2.11%	17,644	1.49%	1,619	1.23%
Medicaid	**Total**	**1,190,597**	**100.00%**	**118,652**	**100.00%**	**1,185,207**	**100.00%**	**131,218**	**100.00%**
Non-Medicaid	**Acadiana Human Services District**	26,501	9.26%	3,787	9.21%	30,585	9.91%	3,844	11.07%
Non-Medicaid	**Capital Area Human Services District**	33,113	11.57%	4,902	11.92%	36,723	11.90%	1,785	5.14%
Non-Medicaid	**Central Louisiana Human Services District**	17,986	6.29%	2,851	6.93%	20,730	6.72%	2,927	8.43%
Non-Medicaid	**Florida Parishes Human Service Authority**	26,342	9.21%	4,188	10.19%	30,337	9.83%	4,277	12.31%
Non-Medicaid	**Imperial Calcasieu Human Service Authority**	14,892	5.21%	3,311	8.05%	16,940	5.49%	897	2.58%
Non-Medicaid	**Jefferson Parish Human Service Authority**	40,356	14.11%	4,605	11.20%	38,248	12.40%	5,064	14.58%
Non-Medicaid	**Metropolitan Human Service District**	52,514	18.36%	4,870	11.84%	49,379	16.01%	3,936	11.33%
Non-Medicaid	**Northeast Delta Human Services District**	21,018	7.35%	3,522	8.57%	24,786	8.03%	3,446	9.92%
Non-Medicaid	**Northwest Louisiana Human Services District**	23,735	8.30%	2,831	6.89%	28,614	9.28%	2,491	7.17%
Non-Medicaid	**South Central Louisiana Human Service Authority**	23,879	8.35%	6,113	14.87%	27,864	9.03%	5,912	17.02%
Non-Medicaid	**Unknown**	5,871	2.05%	257	0.63%	4,363	1.41%	229	0.66%
Non-Medicaid	**Total**	**286,075**	**100.00%**	**41,115**	**100.00%**	**308,492**	**100.00%**	**34,737**	**100.00%**
Unknown	**Acadiana Human Services District**	639	12.55%	639	12.55%	698	12.27%	698	12.27%
Unknown	**Capital Area Human Services District**	642	12.61%	642	12.61%	596	10.48%	596	10.48%
Unknown	**Central Louisiana Human Services District**	222	4.36%	222	4.36%	362	6.36%	362	6.36%
Unknown	**Florida Parishes Human Service Authority**	471	9.25%	471	9.25%	458	8.05%	458	8.05%

Unknown	**Imperial Calcasieu Human Service Authority**	424	8.33%	424	8.33%	513	9.02%	513	9.02%
Unknown	**Jefferson Parish Human Service Authority**	579	11.38%	579	11.38%	855	15.03%	855	15.03%
Unknown	**Metropolitan Human Service District**	546	10.73%	546	10.73%	590	10.37%	590	10.37%
Unknown	**Northeast Delta Human Services District**	323	6.35%	323	6.35%	339	5.96%	339	5.96%
Unknown	**Northwest Louisiana Human Services District**	422	8.29%	422	8.29%	344	6.05%	344	6.05%
Unknown	**South Central Louisiana Human Service Authority**	514	10.10%	514	10.10%	601	10.57%	601	10.57%
Unknown	**Unknown**	373	7.33%	373	7.33%	394	6.93%	394	6.93%
Unknown	**Total**	5,090	100.00%	5,090	100.00%	5,688	100.00%	5,688	100.00%
Total	**Total**	**1,445,985**		**161,570**		**1,455,184**		**168,469**	

Diagnostic Prevalence

The Louisiana Unit evaluated diagnostic prevalence for inpatient and outpatient levels of care. Because inpatient level of care provides care for higher acuity levels, it was believed that level of care was a confounding variable that could extraneously affect the data; thus, inpatient and outpatient level of cares were analyzed separately. DSM-IV coding was used in this analysis. DSM V/ICD-10 coding will be full implemented for the Louisiana Unit in October 2015.

Depressive disorders accounted for the majority of the top ten inpatient diagnoses for all age groups, which was consistent with previous years. Schizophrenia and other psychotic disorders were also highly represented in the adult populations for inpatient diagnoses. ADHD accounted for a majority of the top ten outpatient diagnoses for the 0-21 population. The Louisiana Unit 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. Please see **Section XIV Treatment Record Reviews and Clinical Practice Guidelines** for results of the CPG monitoring.

Top Ten Inpatient Diagnoses

Diagnosis	N_Members	N_Members Served	% of N_Members	% of Top 10 Diagnoses
2014 Inpatient Medicaid 0 - 21 Age Group				
311.00-Depressive disorder, not elsewhere classified	836,342	2,986	0.36%	28.69%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	836,342	2,168	0.26%	20.83%
296.90-AFFECTIVE PSYCHOSIS	836,342	1,696	0.20%	16.30%
296.80-Bipolar disorder, unspecified	836,342	678	0.08%	6.51%

312.30-IMPULSE CONTROL DISORDER	836,342	558	0.07%	5.36%
298.90-Unspecified psychosis	836,342	556	0.07%	5.34%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	836,342	529	0.06%	5.08%
296.23-Major depressive affective disorder, single episode, severe, without mention of psychotic behavior	836,342	498	0.06%	4.79%
296.20-DEPRESS PSYCHOSIS	836,342	419	0.05%	4.03%
312.34-Intermittent explosive disorder	836,342	319	0.04%	3.07%
2014 Inpatient Medicaid 22+ Age Group				
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	348,865	2,783	0.80%	16.91%
295.70-SCHIZOAFFECTIVE	348,865	2,350	0.67%	14.28%
298.90-Unspecified psychosis	348,865	1,844	0.53%	11.20%
311.00-Depressive disorder, not elsewhere classified	348,865	1,720	0.49%	10.45%
295.90-SCHIZOPHRENIA NOS	348,865	1,469	0.42%	8.92%
295.30-PARANOID SCHIZOPHRENIA	348,865	1,393	0.40%	8.46%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	348,865	1,361	0.39%	8.27%
295.34-Paranoid type schizophrenia, chronic with acute exacerbation	348,865	1,257	0.36%	7.64%
295.74-Schizoaffective disorder, chronic with acute exacerbation	348,865	1,176	0.34%	7.14%
296.80-Bipolar disorder, unspecified	348,865	1,109	0.32%	6.74%
2014 Inpatient Non-Medicaid 0 - 21 Age Group				
311.00-Depressive disorder, not elsewhere classified	37,182	58	0.16%	34.52%
298.90-Unspecified psychosis	37,182	23	0.06%	13.69%
296.80-Bipolar disorder, unspecified	37,182	19	0.05%	11.31%
296.90-AFFECTIVE PSYCHOSIS	37,182	17	0.05%	10.12%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	37,182	16	0.04%	9.52%
295.70-SCHIZOAFFECTIVE	37,182	10	0.03%	5.95%
295.90-SCHIZOPHRENIA NOS	37,182	9	0.02%	5.36%
296.70-Bipolar I disorder, most recent episode (or current) unspecified	37,182	7	0.02%	4.17%
296.40-BIPOL AFF, MANIC	37,182	5	0.01%	2.98%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	37,182	4	0.01%	2.38%
2014 Inpatient Non-Medicaid 22+ Age Group				
311.00-Depressive disorder, not elsewhere classified	271,310	623	0.23%	30.66%
298.90-Unspecified psychosis	271,310	301	0.11%	14.81%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	271,310	250	0.09%	12.30%

296.80-Bipolar disorder, unspecified	271,310	193	0.07%	9.50%
295.70-SCHIZOAFFECTIVE	271,310	178	0.07%	8.76%
295.90-SCHIZOPHRENIA NOS	271,310	136	0.05%	6.69%
296.90-AFFECTIVE PSYCHOSIS	271,310	111	0.04%	5.46%
295.30-PARANOID SCHIZOPHRENIA	271,310	110	0.04%	5.41%
296.50-BIPOLAR AFF, DEPR	271,310	70	0.03%	3.44%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	271,310	60	0.02%	2.95%

Top Ten Outpatient Diagnostic Categories

Diagnosis	N_Members	N_Members Served	% of N_Members	% of Top 10 Diagnoses
2014 Outpatient Medicaid 0 - 21 Age Group				
314.01-Attention deficit disorder with hyperactivity	836,342	38,844	4.64%	44.63%
313.81-Oppositional defiant disorder	836,342	10,727	1.28%	12.33%
311.00-Depressive disorder, not elsewhere classified	836,342	8,129	0.97%	9.34%
314.00-ATTENTION DEFICIT DISORDER	836,342	6,475	0.77%	7.44%
312.90-Unspecified disturbance of conduct	836,342	4,604	0.55%	5.29%
300.00-ANXIETY STATE	836,342	4,097	0.49%	4.71%
296.90-AFFECTIVE PSYCHOSIS	836,342	4,013	0.48%	4.61%
314.90-Unspecified hyperkinetic syndrome	836,342	3,842	0.46%	4.41%
309.90-Unspecified adjustment reaction	836,342	3,457	0.41%	3.97%
309.40-Adjustment disorder with mixed disturbance of emotions and conduct	836,342	2,845	0.34%	3.27%
2014 Outpatient Medicaid 22+ Age Group				
311.00-Depressive disorder, not elsewhere classified	348,865	5,135	1.47%	13.09%
295.70-SCHIZOAFFECTIVE	348,865	5,114	1.47%	13.04%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	348,865	4,341	1.24%	11.07%
300.00-ANXIETY STATE	348,865	4,316	1.24%	11.00%
295.30-PARANOID SCHIZOPHRENIA	348,865	4,229	1.21%	10.78%
296.32-Major depressive affective disorder, recurrent episode, moderate	348,865	3,742	1.07%	9.54%
296.80-Bipolar disorder, unspecified	348,865	3,601	1.03%	9.18%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	348,865	2,954	0.85%	7.53%
298.90-Unspecified psychosis	348,865	2,900	0.83%	7.39%
295.90-SCHIZOPHRENIA NOS	348,865	2,893	0.83%	7.38%
2014 Outpatient Non-Medicaid 0 - 21 Age Group				
314.01-Attention deficit disorder with hyperactivity	37,182	239	0.64%	23.16%
304.30-CANNABIS DEPENDENCE	37,182	147	0.40%	14.24%
311.00-Depressive disorder, not elsewhere classified	37,182	114	0.31%	11.05%

296.90-AFFECTIVE PSYCHOSIS	37,182	109	0.29%	10.56%
305.20-CANNABIS ABUSE	37,182	101	0.27%	9.79%
296.80-Bipolar disorder, unspecified	37,182	72	0.19%	6.98%
296.32-Major depressive affective disorder, recurrent episode, moderate	37,182	66	0.18%	6.40%
313.81-Oppositional defiant disorder	37,182	65	0.17%	6.30%
799.90-Other unknown and unspecified cause of morbidity and mortality	37,182	60	0.16%	5.81%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	37,182	59	0.16%	5.72%
2014 Outpatient Non-Medicaid 22+ Age Group				
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	271,310	1,967	0.73%	14.37%
296.32-Major depressive affective disorder, recurrent episode, moderate	271,310	1,825	0.67%	13.33%
303.90-OTHER & UNSPECIFIED ALCOHOL DEPENDENCE	271,310	1,525	0.56%	11.14%
296.80-Bipolar disorder, unspecified	271,310	1,356	0.50%	9.91%
296.30-Major depressive affective disorder, recurrent episode, unspecified	271,310	1,282	0.47%	9.36%
295.70-SCHIZOAFFECTIVE	271,310	1,239	0.46%	9.05%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	271,310	1,187	0.44%	8.67%
304.00-DRUG DEPENDENCE	271,310	1,138	0.42%	8.31%
295.30-PARANOID SCHIZOPHRENIA	271,310	1,113	0.41%	8.13%
296.90-AFFECTIVE PSYCHOSIS	271,310	1,058	0.39%	7.73%

Race and Ethnicity

Racial and ethnic diversity within the Louisiana Unit member population is another important consideration in an effective managed care initiative. There were little changes in the prevalence rates between calendar years 2013 and 2014 for both race and ethnicity. The Black/African American race showed the highest prevalence in both eligibility (51.05%) and members served (50.99%), with the white race showing the second highest prevalence rate in eligibility (37.81%) and members served (42.67%). Ethnicity data indicated that the Non-Hispanic/Non-Latino population represented the highest prevalence for eligibility (96.35%) and members served (98.65%). Comparison of eligibility and members served populations showed consistent representation for both race and ethnicity. As seen in the previous contract year, Magellan received no member grievances between March 1, 2014-February 28, 2015 related to ethnic/cultural or linguistic issues as perceived and reported by the member. There are no notable opportunities for improvement identified for 2015.

Race

		Calendar Year 2013				Calendar Year 2014			
Medicaid Status	**Race**	N_Members	Prevalence	N_Members Served	Prevalence	N_Members	Prevalence	N_Members Served	Prevalence

Medicaid	American Indian/Alaskan Native	4,708	0.40%	534	0.45%	4,669	0.39%	574	0.44%
Medicaid	Asian	12,801	1.08%	366	0.31%	13,010	1.10%	346	0.26%
Medicaid	Black/African-American	613,637	51.54%	59,057	49.77%	605,033	51.05%	66,905	50.99%
Medicaid	Multi-Racial	5,890	0.49%	552	0.47%	6,811	0.57%	632	0.48%
Medicaid	Native Hawaiian/Pac Islander	948	0.08%	52	0.04%	1,090	0.09%	62	0.05%
Medicaid	Other/Single Race	31	0.00%	0	0.00%	39	0.00%	22	0.02%
Medicaid	White	455,481	38.26%	52,508	44.25%	448,116	37.81%	55,993	42.67%
Medicaid	Unknown	97,981	8.23%	6,043	5.09%	106,953	9.02%	6,986	5.32%
Medicaid	Total	1,190,597	100.00%	118,652	100.00%	1,185,207	100.00%	131,218	100.00%
Non-Medicaid	American Indian/Alaskan Native	773	0.27%	97	0.24%	886	0.29%	92	0.26%
Non-Medicaid	Asian	3,873	1.35%	68	0.17%	3,665	1.19%	61	0.18%
Non-Medicaid	Black/African-American	114,994	40.20%	7,135	17.35%	118,669	38.47%	6,624	19.07%
Non-Medicaid	Multi-Racial	1,013	0.35%	124	0.30%	1,491	0.48%	151	0.43%
Non-Medicaid	Native Hawaiian/Pac Islander	222	0.08%	15	0.04%	234	0.08%	14	0.04%
Non-Medicaid	Other/Single Race	2	0.00%	0	0.00%	6	0.00%	4	0.01%
Non-Medicaid	White	84,600	29.57%	10,692	26.01%	91,642	29.71%	10,307	29.67%
Non-Medicaid	Unknown	80,757	28.23%	23,051	56.06%	92,024	29.83%	17,516	50.42%
Non-Medicaid	Total	286,075	100.00%	41,115	100.00%	308,492	100.00%	34,737	100.00%
Unknown	Total	5,090	100.00%	5,090	100.00%	5,688	100.00%	5,688	100.00%
Total	Total	1,445,985		161,570		1,455,184		168,469	

Ethnicity

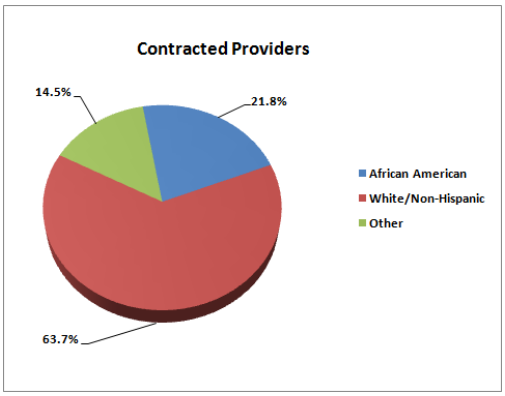
		Calendar Year 2013				Calendar Year 2014			
Medicaid Status	Ethnicity	N_Members	Prevalence	N_Members Served	Prevalence	N_Members	Prevalence	N_Members Served	Prevalence
Medicaid	HISPANIC OR LATINO	39,171	3.29%	1,375	1.16%	43,287	3.65%	1,781	1.36%
Medicaid	NON-HISPANIC OR NON-LATINO	1,151,406	96.71%	117,290	98.85%	1,141,917	96.35%	129,440	98.65%
Medicaid	Unknown	58	0.00%	0	0.00%	14	0.00%	1	0.00%
Medicaid	Total	**1,190,597**	**100.00%**	**118,652**	**100.00%**	**1,185,207**	**100.00%**	**131,218**	**100.00%**
Non-Medicaid	HISPANIC OR LATINO	9,060	3.17%	265	0.64%	8,671	2.81%	284	0.82%
Non-Medicaid	NON-HISPANIC OR NON-LATINO	225,731	78.91%	21,372	51.98%	238,408	77.28%	19,803	57.01%
Non-Medicaid	Unknown	51,312	17.94%	19,479	47.38%	61,440	19.92%	14,650	42.17%
Non-Medicaid	Total	**286,075**	**100.00%**	**41,115**	**100.00%**	**308,492**	**100.00%**	**34,737**	**100.00%**

Unknown	**Unknown**	5,090	100.00%	5,090	100.00%	5,688	100.00%	5,688	100.00%
Unknown	**Total**	**5,090**	**100.00%**	**5,090**	**100.00%**	**5,688**	**100.00%**	**5,688**	**100.00%**
Total	**Total**	**1,445,985**		**161,570**		**1,455,184**		**168,469**	

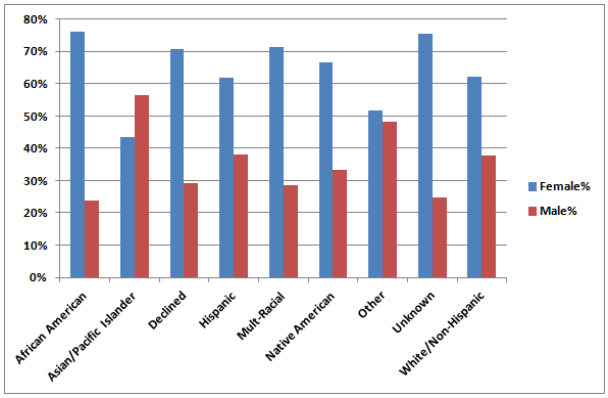
B. Provider Network Demographics

The demographic composition of the Louisiana Unit provider network 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 member 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. 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, it also helps bridge possible mistrust or historical trauma experienced by diverse populations. The following are graphical representations of contracted individual practitioners by race and gender (includes self reported data provided by practitioners) as of February 28, 2015.

Individual Practitioners by Race



Individual Practitioners by Race & Gender



Member demographics indicated that in 2014 African Americans comprise over half of the members served; however, only 21.8% of individual practitioners are African American as of February 28, 2015. Although there are differences in the practitioner and member mix, Magellan implements a robust cultural competency program to educate providers and ensure services are delivered in a culturally competent manner. Cultural competency training is included as part of provider orientation and

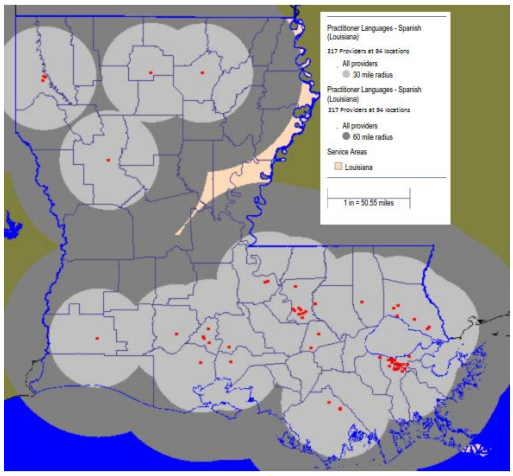
ongoing training is provided by the Louisiana Unit to its staff and providers. Magellan also makes a Cultural Diversity Toolkit available to support both staff and providers in working with members. Full details on the 2015 Cultural Competency Plan are discussed later in this section.

Language Needs

The Louisiana population served by the Louisiana Unit represents a diverse culture and Magellan has implemented services to address the language needs of minority members served, including access to translation services for members who require translations. Magellan monitors its practitioner network and tracks the languages spoken in order to meet identified member needs whenever possible. 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 20 language services other than English. There are 610 distinct practitioners at 208 service points who offer language proficiencies other than English, with Spanish having the highest representation. The below chart shows the distinct number of practitioners and service points for the languages offered.

Language	Count	Service Points
SPANISH	317	94
HINDI	176	54
FRENCH	159	47
ARABIC	135	26
TAGALOG	129	22
TELUGU	28	16
PORTUGUESE	31	12
PUNJABI	69	11
BURMESE	56	10
URDU	51	9
SIGN LANGUAGE	3	4
CREOLE (Haitian)	6	3
GUJARATI	14	3
SWEDISH	5	2
VIETNAMESE	1	2
AFRIKAANS	2	1
DUTCH	1	1
GREEK	4	1
INDIAN	1	1
RUSSIAN	15	1

The Geo Map below represents Spanish language services by LBHP providers which are available to members across the state. The dark gray spheres indicate the 60 mile radius of coverage. There are 317 providers at 94 locations who offer Spanish language services.



Although not all members have access to a provider offering Spanish language services, Magellan does offer Translation/Interpretation Services to all members. Magellan also tracks member grievances to identify if there are issues related to language. Magellan did not receive any grievances regarding language in contract year three.

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 2014, Global reported 66 appointments for American Sign Language (ASL) interpretation services and 55 appointments for language interpretation services.

C. 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 Louisiana Unit.

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 use services.

Magellan maintains a strong focus on continuous quality improvement. Each department manager or supervisor is accountable for the success of the program through integration of the principles of cultural competency in all aspects of organizational planning and working to assure cultural competence at each level within the system. The Louisiana Unit 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 cultural competency policies and procedures, related program correspondence and quality improvement documents – including this program evaluation – are subject to regular review through the Quality Improvement Program and structures. Magellan's Race and Equity Committee (REC) is established to ensure the quality management program reviews and analyzes program data to evaluate racial and ethnic disparities in utilization patterns, outcomes, satisfaction, and provider cultural competency. The REC also oversees the cultural competency work plan and reports to the Quality Improvement Committee (QIC). As referenced above, the QI Program includes indicators to assure equal delivery for all services described in the program description. Indicators include, but are not limited to:

- Member grievances and provider complaints, including monitoring of grievances for issues that are potentially related to culturally insensitive practices.
    - There were no grievances related to cultural issues in contract year three.
    - There have not been any grievances reported related to cultural issues since implementation of the contract in 2012.
- 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 (see **Provider Network Demographics** in this section).
- Treatment Record Review monitoring.
    - Magellan also monitors providers to ensure services are delivered in a culturally competent manner. Magellan includes two elements in the audit tools that are utilized to monitor for documentation for quality standards. Records were reviewed at 193 providers during contract year three. The below elements are evaluated by licensed clinicians during record reviews across all levels of care.

- The results indicate both elements were above the 80% minimum threshold and no quality of care concerns were identified.

Treatment Record Review Element	Records in Compliance	Total Records Reviewed	Compliance Rate
8E Evidence of treatment being provided in a culturally competent manner.	1751	1841	95.7%
1B Cultural, language, religious, racial, ethnic, and sexual issues were assessed.	1687	1824	93.6%

- Satisfaction survey data related to cultural competency.
  - Member perception of experience of care is an essential component of monitoring the quality of provider service delivery. Two elements are monitored during Magellan's annual member satisfaction survey to assess member satisfaction related to cultural issues.

Question		% Positive		
		CY1	CY2	CY3
Q17	Staff members were sensitive to my cultural background (race, religion, language, customs, etc)	84.8%	87.4%	85.1%
Q18	My cultural preferences and race/ethnic background were included in planning services I received.	72.1%	72.4%	74.2%

  - Magellan establishes a minimum threshold of 80% when analyzing satisfaction survey data. Although there have been steady improvements in this measure since CY1, element Q18 (My cultural preferences and race/ethnic background were included in planning services I received) was identified as an opportunity for improvement. Further analysis indicated that there was 91.2% satisfaction for this element when evaluating positive and neutral responses, indicating many people maybe impartial but not necessarily dissatisfied. Magellan conducts annual population assessment and cultural competency plans to guide the program around cultural needs of the state. Magellan will implement interventions in contract year four to address the following: sharing results with practitioners and stakeholders to increase awareness of member perception of cultural sensitivity and implementing trainings to promote patient centered treatment planning that includes assessing for and addressing cultural background during treatment.

Magellan facilitated a number of cultural competency trainings to accomplish our contract year three goal of advancing cultural competency initiatives within the provider network. This included the following conferences and trainings for behavioral health and chemical dependency counselors:

- 12th Annual Conference on Behavioral Health, Monroe, LA

- National Association of Social Workers (NASW) Annual Conference, Baton Rouge, LA
- 2014 National Alliance on Mental Illness (NAMI) State Conference, Baton Rouge, LA
- 2014 Louisiana Association of Substance Abuse Counselors and Trainers, Inc. (LASACT) Conference, New Orleans, LA
- 12th Annual Together We Can (TWC) - Make a Difference for Abused and Neglected Children Conference, Lafayette, LA
- 2nd Annual Community Integration and Recovery Academy (CIRA) Conference, New Orleans, LA
- Success Insite Children & Family Counseling, Bossier City, LA
- Gulf Coast Social Services, Houma, LA
- Goodwill Industries of North Louisiana, Inc. Alexandria, LA
- Ekhaya Family Support Organization (FSO), Alexandria, LA
- Ekhaya Family Support Organization (FSO), Monroe, LA
- Ekhaya Family Support Organization (FSO), Shreveport, LA

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

	Identified Objective	Action Steps
1	Increase awareness of the role culture and life experiences can have on the services individual behavioral health providers offer and also on the seeking and receiving service decisions an individual member may encounter.	Identify, develop and provide trainings that are specific to culturally competent care, language access services, decrease of stigma and organizational supports.
		Monitor Magellan cultural competency trainings for new and existing employees.
2	Increase awareness of Louisiana Native American Tribes.	Develop and provide information that is specific to the four federally known tribes in Louisiana. Face to face training will be provided to contracted providers on request.
3	Participation in conferences, seminars, forums, committees etc. related to cultural competency topics and reducing health disparities.	Cultural Competency Department will participate in the planning, implementation and volunteering at various events focusing on cultural competency and reducing health disparities.
4	Development, production, and delivery of Cultural Competency Trainings to include Cultural and Linguistic Appropriate Services (CLAS) Standards.	Participate in workgroup created to develop Cultural Competency Training Curriculum for new employees and staff.
		Technical Assistance (TA) by email, phone, and face to face will be provided on a need basis to contracted providers.
5	Pursue partnership efforts with external agencies to ensure collaboration with diverse programs and initiatives in order to enhance services.	Initiate contact and explore collaboration with outside agencies.
		Set up meetings with each potential partner.
		Participate in committees or workgroups ofpotential partners
6	Collaborate with Magellan's Quality Improvement (QI) Department to determine the monitoring and reporting regarding cultural competency.	Work in conjunction with QI Department:
		To review members' and providers' grievances and appeals for the presence of cultural competency components.
		Monitor the administration of the Member Satisfaction Survey and the Provider Satisfaction Survey for the presence of cultural competency components.

7	Collaborate with marketing efforts to ensure the development and dissemination of culturally sensitive healthcare promotional material	Utilize materials in electronic and/or print form to promote culturally sensitive information representative of clients' served.
8	Based on data and reports received from all areas of Magellan in Louisiana, the Race Equity Committee will generate recommendations for the appropriate implementation of CLAS.	REC will use the data analysis provided to identify the existing culturally appropriate strategies andservices and initiatives for diverse populations.
		Validate existing services and initiatives for the identified populations to improve the number of members accessing, engaging and retaining behavioral health services.
9	Identify methods to monitor internal compliance of CLAS Standards and make recommendations.	Identify existing documentation or data for the presence of CLAS Standards.
		Provider manual is revised as needed to include updated cultural competency information.
		Monitor Language Interpretation Utilization.
		Request database to review phone calls for CLAS Standard competency.

III. Accessibility and Availability of Services

Since the inception of the LBHP, the array of services available to both adults and youth has grown significantly. The network serving members along the continuum of behavioral health services from inpatient to community-based services has not only grown in size but has seen significant advances in the development of new programs to meet member needs allowing more Louisianans access to behavioral health services including basic, expanded specialized, and waiver services.

In collaboration with DHH-OBH, DCFS, OJJ, LDOE, providers, members and stakeholders across Louisiana, Magellan has proudly assisted in building the infrastructure that is now beginning to move the system of care from a focus on inpatient services to a community-based system that provides members with access to timely evidence-based, fully coordinated and integrated services which focus on enhancing the member's ability to remain in their home and community setting as much as possible. We have expanded and added a number of providers to the behavioral health continuum including ACT/FACT, PSR, CPST, and CI among many others for adults, and TGH, NMGH, TFC, MST and Homebuilders for children and adolescents. Magellan successfully supported the development of the statewide Coordinated System of Care (CSoC) for children that offers a wide range of services and effectively uses the services of Wraparound Agencies (WAAs). Substance use disorder services have been brought under the Medicaid umbrella, and we continue to expand in this area including inpatient, residential and outpatient detox, intensive outpatient, and suboxone treatment. This section outlines key quality indicators for accessibility and availability of services, including telephone responsiveness standards, appointment access standards, and geo-access and density standards.

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, 2014 to February 28, 2015. The goal for abandoned calls is 3% or fewer, and the goal for ASA is 30 seconds or less. Over the year, 139,062 calls were answered with a 19-second ASA and a 2.70% abandonment rate, meeting contractual performance guarantee goals for telephonic responsiveness. There was a slight increase in the abandonment rate and ASA in contract year three; however, all goals were met. The increase is attributed to better management of resources to support other aspects of the Louisiana Unit while still maintaining telephone responsiveness standards. No opportunities for improvement were identified to telephone accessibility standards.

Telephone responsiveness	Contract YTD
Numerator (number of abandoned inbound calls)	3,749
Denominator (Total number of inbound calls)	139,062
Call Abandonment Rate - Member/ Provider Services Line(s) 3% percent or less	2.70%
Numerator (Total average seconds to answer)	2,540,349
Denominator (Total calls answered)	132,838
Average Speed to Answer (ASA) in seconds– Member/Provider Services Line(s) all calls (pooled) answered within an average of 30 seconds	19.12

Telephone responsiveness	Contract Year 1	Contract Year 2	Contract Year 3
Call Abandonment Rate (Goal: 3%)	1.39%	2.57%	2.70%
Average Speed to Answer (ASA) in seconds (Goal: 30 seconds)	7.4	16.58	19.12

B. Appointment Access

Magellan categorizes appointments as routine, urgent, and emergent. Appointment access standards are discussed fully in **Section V Quality Improvement Activities and Performance Improvement Projects** for full report on this metric.

C. Geo-Access & Density Accessibility

Magellan has an established LBHP behavioral health provider network consisting of licensed mental health professionals, hospitals, youth residential facilities, residential substance use facilities, substance use IOP and OP providers, evidence-based practice service providers and home and community-based service providers for adults and children. Magellan implements processes and procedures that address network development and recruitment. Our goal is not only to maintain a comprehensive network that is consistent in size and variety to meet the needs of Louisiana Medicaid managed care members, but to identify opportunities to invest in the delivery system resulting in improved service access and improved member outcomes. The Network Strategy Committee (NSC) oversees the Network Development Plan and reports to the Quality Improvement Committee (QIC). The NSC is established to ensure the quality management program reviews and analyzes program data to accessibility indicators, including in 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. A gap in services is defined when geo-access standards fall below 90% for urban and rural areas. When opportunities for improvement are identified,

the Network Services Department develops a provider recruitment plan and the NSC monitors its effectiveness in addressing gaps.

Geographic access standards are established to ensure that contracted practitioners and facilities are available in the communities in which members reside. Magellan evaluates provider types 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 chart below outlines the geo-access rates as of February 28, 2015. Magellan was above 90% compliance for all provider types.

Provider Type	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	0.7	462,348	-	462,348	100.0%
Outpatient	Rural	- 60 miles	4.3	865,667	-	865,667	100.0%
Inpatient	Urban/Suburban	- 30 miles	3.2	462,348	-	462,348	100.0%
Inpatient	Rural	- 60 miles	12.2	864,557	1,110	865,667	99.9%
Non Prescribers	Urban/Suburban	- 30 miles	1.9	462,348	-	462,348	100.0%
Non Prescribers	Rural	- 60 miles	12.4	865,502	165	865,667	100.0%
Prescribers	Urban/Suburban	- 30 miles	1.3	465,348	-	465,348	100.0%
Prescribers	Rural	- 60 miles	7.4	865,214	453	865,667	99.9%
Mental Health Rehab	Urban/Suburban	- 30 miles	1.4	462,348	-	462,348	100.0%
Mental Health Rehab	Rural	- 60 miles	7.1	865,223	444	865,667	99.9%
CSOC	Urban/Suburban	- 30 miles	8.2	417,809	44,539	462,348	90.4%
CSOC	Rural	- 60 miles	28.2	792,653	73,014	865,667	91.6%
Residential	Urban/Suburban	- 30 miles	3.4	461,499	849	462,348	99.8%
Residential	Rural	- 60 miles	25.6	799,110	66,557	865,667	92.3%

The NSC also looks at overall network growth. Please see the chart below for details on network development by facility, group, and practitioners.

Overall Network Development since Implementation in March 2012

Month	Facilities	Groups	Practitioners	Grand Total
3/1/2012	114	84	416	614
4/1/2012	130	89	466	685
5/1/2012	132	96	481	709
6/1/2012	154	101	648	903
7/1/2012	203	115	733	1,051
8/1/2012	221	125	831	1,177
9/1/2012	361	135	1,011	1,507

10/1/2012	407	139	1,139	1,685
11/1/2012	419	145	1,226	1,790
12/1/2012	435	152	1,274	1,861
1/1/2013	444	172	1,313	1,929
2/1/2013	459	177	1,342	1,978
3/1/2013	462	177	1,372	2,011
4/1/2013	483	184	1,407	2,074
5/1/2013	495	194	1,443	2,132
6/1/2013	506	202	1,476	2,184
7/1/2013	524	205	1,536	2,265
8/1/2013	532	206	1,651	2,389
9/1/2013	537	209	1,679	2,425
10/1/2013	554	215	1,761	2,530
11/1/2013	564	220	1,790	2,574
12/1/2013	609	227	1,930	2,766
1/1/2014	615	230	1,999	2,844
2/1/2014	630	234	2,046	2,910
3/1/2014	636	239	2,124	2,999
4/1/2014	651	242	2,155	3,048
5/1/2014	655	247	2,185	3,087
6/1/2014	674	251	2,194	3,119
7/1/2014	685	255	2,217	3,157
8/1/2014	711	260	2,289	3,260
9/1/2014	719	266	2,378	3,363
10/1/2014	727	269	2,439	3,435
11/1/2014	732	277	2,467	3,476
12/1/2014	748	283	2,511	3,542
1/1/2015	758	290	2,547	3,595
2/1/2015	780	303	2,582	3,665
3/1/2015	782	304	2,615	3,701

Another important metric that is monitored by the NSC is prescriber growth. There has been a 512.1% increase in providers from March 1, 2012 to February 28, 2015 and a 17.8% increase since March 1, 2014.

Growth of Prescribers since Implementation in March 2012

Date	APRN Prescriber	Medical Psychologist	Psychiatrist	Total Prescribers
3/1/2012		3	63	66
3/31/2012	2	3	80	85
4/30/2012	3	3	84	90
5/31/2012	4	3	98	105
6/30/2012	4	4	107	115
7/31/2012	4	5	127	136
8/31/2012	4	5	163	172

9/30/2012	4	5	178	187
10/31/2012	4	5	191	200
11/30/2012	4	6	198	208
12/31/2012	4	7	204	215
1/31/2013	4	7	205	216
2/28/2013	4	8	209	221
3/31/2013	4	9	214	227
4/30/2013	4	9	217	230
5/31/2013	4	9	222	235
6/30/2013	4	9	230	243
7/31/2013	4	10	242	256
8/31/2013	4	10	245	259
9/30/2013	4	11	280	295
10/31/2013	4	13	284	301
11/30/2013	4	13	296	313
12/31/2013	7	14	307	328
1/31/2014	7	14	320	341
2/28/2014	7	14	322	343
3/31/2014	7	14	323	344
4/30/2014	9	14	329	352
5/31/2014	9	14	330	353
6/30/2014	9	14	332	355
7/31/2014	10	14	336	360
8/31/2014	10	14	339	363
9/30/2014	10	14	348	372
10/31/2014	11	15	351	377
11/30/2014	11	15	360	386
12/31/2014	13	16	365	394
1/31/2015	16	16	368	400
2/28/2015	16	16	372	404

In addition to geo-access and provider growth, Magellan continues to actively monitor member accessibility through other 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 has also 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 aggregated and monitored to determine if there are regional or provider trends. 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.

In contract year four, Magellan will continue to focus interventions on meeting the objectives associated with our goal of enhancing services and the experience of care for members. Magellan will do the following in contract year four:

- Monitor and assist in the expansion of the youth residential system in partnership with Seaside Healthcare, which will include the addition of 15 Therapeutic Group Homes. This includes 5 homes in New Orleans, 4 homes in Baton Rouge, 4 homes in Shreveport, and 2 homes in Lafayette.
- Continue to analyze network composition through review of ad hoc reporting. Initiate recruitment efforts in areas where frequent ad hocs are completed due to lack of network availability. Any time our ad hoc agreement increases by more than 25% within Louisiana, or we see a significant increase in trend over a 2 month time frame, this will prompt recruitment activities. Also, if we complete multiple ad hocs for a particular provider, we will reach out and attempt to recruit the provider.
- Maintain ongoing support and training to current and new providers.
- Work with currently contracted providers who approach us to add new services to existing contracts through the end of the contract.

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

The Magellan Health Services Louisiana Unit Quality/Clinical Work Plan for Louisiana Behavioral Health Partnership sets forth all the performance measures and activities for services managed by the Louisiana Unit. 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.

2014-15 Objectives:

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
    - Status: Accomplished.
    - FFT showed a significant upward trend in utilization with services being provided during 2014. There was decline in the utilization of Homebuilders, an EBP aimed to enable children to remain in the home; however, Magellan also implemented the Coordinated Systems of Care statewide based on Hi-Fidelity Wraparound, which can also be utilized by children at high risk for out of home placement.
2. Improve follow up after hospitalization 7-day rates and 30-day rates
    - Status: Continue into Contract Year Four.
    - Magellan showed improvement for both 7- and 30-day rates from 2013; however continued progress is needed to meet long-term NCQA goals of 46% and 65% for 7- and 30-day follow up respectively.
    - In contract year three, Follow-up After Hospitalization Performance Improvement Plan was expanded to the Transitional Care PIP to improve capabilities to monitor the quality of care for those who receive Inpatient services more comprehensively. Metrics for discharge components, readmission, and Bridge of Discharge (BOD) programs were added.
    - Initial BOD program data showed positive outcomes in contract year three (e.g., improved FUH rates for those receiving BOD appointment). Magellan will expand the

program to include a high-volume inpatient provider serving the New Orleans area in contract year four.
    - Please see **Section V Quality Improvement Activities and Performance Improvement Projects** for the full report on the Transitional Care PIP.
3. Increase member access to peer support and crisis services.
    - Status: Deferred.
    - In contract year three, Magellan worked collaboratively with Medicaid and OBH to expand access to crisis intervention and peer support to all adult Medicaid members via "In Lieu Of" amendments; however, due to the discontinuation of the contract in November 2015, Magellan will focus efforts to transitioning the network to an integrated medical/behavioral health model.
4. Preserve member experience of care at greater than or equal to 83%.
    - Status: Accomplished.
    - 2014-15 Member Satisfaction was 83.1%.
    - Interventions to ensure continuous quality improvement will be implemented in contract year four.
    - Please see **Section XIX Satisfaction Surveys and Grievances** for a full evaluation of the member satisfaction survey results.
5. Develop utilization management approaches and strategies to maximize the impact of Magellan's involvement in care.
    - Status: Accomplished. Will be continued into contract year four.
    - In contract year three, Magellan implemented an admissions team to improve coordination of care between IP and OP providers and High Complexity Member Rounds for members with SMI. Magellan continues to show meaningful improvement for members participating in these rounds. Please see **Section VI Care Management Initiatives** for a full evaluation of these interventions.
    - In contract year three, Magellan implemented a new service type, the Independent Assessment/Community-Based Care Management service, to ensure high need members are appropriately assessed and connected to the appropriate intensity of services to meet their needs.
6. Advance cultural competency initiatives for provider network increased trainings and provider monitoring.
    - Status: Accomplished. Will be continued into contract year four.
    - Facilitated twelve conferences and trainings for behavioral health and chemical dependency counselors during 2014.
    - Magellan added elements to the Treatment Record Review tool to monitor cultural competency of service delivery that showed compliance rates above 90%.

- Please see Section **II Population Description: Demographics, Cultural Competency Assessment and Diagnostic Prevalence** for details on the cultural competence program and trainings.

7. Establish reporting processes for ongoing oversight and outcomes monitoring of highly utilized services.
    - Status: Accomplished. Will be continued into contract year four.
    - UMC implemented the use of control charts to monitor over and under utilization of services to identify opportunities for improvement. See **Section VIII Evaluation of Over/Under Utilization of Services** for examples of control charts.
    - WAA and IA/CBCM develop the member's plan of care and monitor of utilization of waiver and HCBS services.
    - UM implemented admissions team intervention, high complexity rounds, referral to complex case management, and outlier facility interventions to improve readmission rates, FUH rates, and ALOS. Outcomes for these interventions in contract year three include: Reduced overall readmission rate by 33.2% from contract year two, with a rate of 7.8%. There were also slight improvements to FUH rates and downward trending in ALOS. Please see **Section VI Care Management Initiatives** for a full evaluation of these initiatives.
8. Expand performance-based provider initiatives, as a method by which to increase provider accountability for outcomes.
    - Status: Accomplished. Will continue into contract year four.
    - Magellan has implemented two "scorecards" for evidence based practices with a set of performance measures balancing services, fidelity, and outcomes, with the ACT scorecard already tied to a pay-for-performance model. The ACT scorecard has already demonstrated improved outcomes, including a 15.7% decrease in readmissions, 12.7% decrease in admissions per hundred and 10.52% decrease in ALOS.
9. Provide ongoing oversight and compliance monitoring of Home and Community Based Service (HCBS) and Coordinated Systems of Care (CSoC) providers
    - Status: Accomplished. Will continue into contract year four.
    - CSoC monitoring process is established. IMT performance measures evaluate progress towards the goal of 100% compliance. Currently 19 of the 21 measures are consistently meeting 100% threshold. One measure is under 86% (i.e., did the member receive services in the type, amount, duration and frequency specified in the plan of care). Magellan initiated a new data collection methodology in collaboration with OBH for contract year four that will allow for remediation for each case that is not in compliance.
    - Magellan implemented a new service type, the Independent Assessment/Community-Based Care Management service, to ensure high need members are appropriately assessed and connected to the appropriate intensity of services to meet their needs.

IMT performance measures evaluate progress towards the goal of 100% compliance. Currently 11 of the 17 measures are consistently meeting 100% threshold. Only two measures fall below under 86% (i.e., Number and/or percent of participants whose plans of care were updated within 90 days of the last evaluation; and Number and/or percent of participants whose plans of care were updated when warranted by changes in the participants' needs.) In contract year four, Magellan will implement targeted trainings for providers on these performance measures.

10. Maintain all performance guarantee measures and do not show a decline in current measurements.
    - Status: Accomplished.
    - All metrics were met for contract year three.
    - IMT performance measures are addressed in grid below.

Performance Guarantees

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

Performance Guarantees	2014-15 Goal	Met / Not-Met (Year to Date)	Actions to Address
Claims administration			
Financial payment (dollar) accuracy-97% of audited claim dollars paid accurately	97%	99.75%	Continue to Monitor
Claims Accuracy	98%	99.81%	Continue to Monitor
TAT – 95% of clean claims paid to all providers within 30 days	95%	97.60%	Continue to Monitor
TAT – 99% of all provider claims paid within 45 days	99%	99.88%	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%	2.70%	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	19.12 seconds	Continue to Monitor
Clinical			
Ambulatory follow up within 7 days of discharge from 24-hour facility	28%	32.16%	Although this metric met the internal goal, the Louisiana Unit 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%	50.70%	Although this metric met the internal goal, the Louisiana Unit 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%	7.89%	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%	26.6%	Continue to Monitor
Satisfaction			
Annual Member Satisfaction Survey:	83%	83.1%	Although goal was met, an Action Plan implemented for measures below 80% in an effort for CQI
Annual Provider Satisfaction Survey:	80%	87.7%	Although goal was met, an Action Plan implemented for measures below 75% in an effort for CQI

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 purposes 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 include metrics that assess Access, Administrative Compliance, Survey Data, Eligibility, Member 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. 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, 38 currently met the 100% compliance standard in contract year three quarter four. Eight of the PMs did not meet the compliance standard. Of the eight, only three fell below the 86% threshold and require system-wide corrective action plans. Please see detailed report on the performance measures and associated corrective action plans in **Appendix C Interdepartmental Monitoring Team (IMT) Performance Measures.** In contract year three, Magellan fully implemented a single statewide Independent Assessor/Community-Based Care Manager approach in order to improve compliance with these metrics. Standardized forms were also implemented to ensure consistent documentation of required performance measures. Please see **Section XVII Behavioral Continuum (System Transformation)** for full details on the implementation. The following charts represent interventions that were implemented to improve compliance related to Treatment Planning, Access, and Grievances. Magellan will continue to work collaboratively with the IMT to monitor effectiveness of interventions throughout the fourth 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 levels of care 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	QI Clinical Reviewers	March 2012-ongoing

	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.		
	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 are 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 Corrective Action Plan (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 are 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 deficiencies will be corrected.	QI Manager	October 2014

Access to Care Interventions

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 Louisiana Unit, 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 who contact Magellan seeking assistance in obtaining appointment; outpatient support specialists and/or care managers will assist member in securing 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
TGH Development	Monitor and assist in the expansion of the youth residential system in partnership with Seaside Healthcare, which will include the addition of 15 Therapeutic Group Homes. This includes 5 homes in New Orleans, 4 homes in Baton Rouge, 4 homes in Shreveport, and 2 homes in Lafayette.	Network Administrator	August 2014-November 2015

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 Louisiana Unit also works with contract monitors to determine if statewide improvements are needed. The Louisiana Unit conducted four 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 four formal PIPs for contract year three 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; Transitional Care, and Improving Adverse Incident Reporting. Information will be presented using the standardized IPRO format. Each project will include details on the project topic, methodology, interventions, results and conclusions.

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

Project Topic

1. Describe Project Topic

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 contract years one through three.

2. Rationale for Topic Selection

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 Unit to monitor the promptness with which members are able to access emergent, urgent, and routine services.

3. Aim Statement

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. This is done by monitoring appointment access indicators, including grievance and satisfaction survey data, and implementing interventions when opportunities for improvement are identified.

Methodology

1. Performance Indicators

A. Indicator One: Time from request for service to authorization of service

This indicator assesses the percentage of members who receive an authorization for service within required timeframes.

Denominator (3): Total number of authorization requests that are classified as emergent, urgent, and routine by care manager at the time of request.

Numerators (3): Number of authorization completed within established timeframes.

B. Indicator Two: Time from request for service to member accessing service

This indicator assesses the percentage of members who access service within the required timeframe. Timeframes for emergent access are within one hour of request, urgent access within 48 hours/2 calendar days and routine access within 14 calendar days. Classification of appointment urgency is authorization based and reports are pulled form Magellan's Integrated Product (IP) database. Services access is claims based metric. Access is evaluated against

corporate access goals of 95% for emergent and urgent appointment access and 70% for routine access.

Denominator (3): Total number of authorization requests that are classified as emergent, urgent, and routine by care manager at the time of request.

Numerators (3): Number of members that request service and then receive service as evidenced by a claim within the established timeframe based on appointment classification.

C. **Indicator Three:** Member satisfaction with access to care

This indicator assesses members' perceived satisfaction with access to care. The Louisiana Unit utilizes the Magellan Member Experience of Care survey to measure satisfaction. Magellan sets an internal corporate goal of reaching 80% positive satisfaction responses per element. Opportunities for improvement are identified as elements falling below that threshold.

Denominator (11): Total number of members that responded to each element. There are five elements for the minor (under 18) and six elements for the adult (18+) population.
The following elements were utilized to determine satisfaction with access to care:

- Staff was willing to see my child as often as I felt was necessary.
- Staff returned our call(s) in 24 hours.
- Services were available at times that were good for us.
- The time my child waited between appointments was acceptable.
- My family got as much help as we needed for my child.
- My child was able to see a psychiatrist when he/she wanted to.

Numerators (11): Number of members that responded positively to each element.

D. **Indicator Four:** Member grievances regarding access to care

This indicator assesses members' dissatisfaction with access to care.

Number: The number of grievances filed by members of all ages related to access to care. Number is tracked over time.

2. Procedures

A. Indicator 1: Data collected from Magellan utilization management system (IP) using the Date of Request to Date of Decision fields. Timeframes for emergent access are within one hour of request, urgent access within 48 hours/2 calendar days and routine access within 14 calendar days. This indicator is authorization based and reports are pulled from Magellan's Integrated Product (IP) database. They are evaluated against corporate access goals of 95% for emergent and urgent appointment access and 70% for routine access. Care Managers make clinical determinations at the time of request to categorize requests. Magellan has a bilateral approach to monitoring classifications of appointments. One is established for appointments requested via verbally and one is established for requests submitted via facsimile transmission. Magellan utilizes the following definitions to classifying appointments:

> *Emergent – An individual in need of an emergent appointment is at serious or extreme risk of harm, such as current suicidal ideation with expressed intentions, recent use of substances resulting in decreased inhibition of harmful behaviors, repeated episodes of violence toward self or others, or extreme compromise of ability to care for oneself leading to physical injury.*
>
> *Urgent – An individual in need of an urgent appointment is at moderate risk of harm, such as suicidal ideation without intent or binge use of substances resulting in potentially harmful behaviors without current evidence of such behavior.*
>
> *Routine – An individual in need of a routine appointment is at minimal to low risk of harm, such as absence of current suicidal ideation or substance use without significant episodes of potentially harmful behavior.*

As defined, emergent and urgent appointments are driven by the request of the member or a provider on behalf of a member. The access to service process and standards are applicable for members who are not in a healthcare setting at the time of contact with Magellan. Emergent and urgent requests are handled telephonically. When members or providers on behalf of members contact Magellan by telephone, they are assessed for the level of clinical urgency (i.e., emergent, urgent or routine, including members that selected the crisis option on the call-in menu). A member identified as experiencing a life-threatening emergent level of clinical urgency is assisted by the Magellan care management staff with securing transport to an emergency room and a 9-1-1 call out as necessary. When a member is not currently in service with a behavioral health provider and is assessed at an urgent level of clinical urgency, the Magellan care management staff assists the member in securing an appointment with a network provider within the required timeframe (i.e., 48 hours). Members currently being treated by a behavioral health provider and assessed as non-life threatening or urgent level of clinical urgency are referred to their treating provider for direction. It is important to note that contact with Magellan is often not necessary for provider to address urgent needs. Member

benefits include pass-through therapy services, which can to be utilized to address urgent needs if necessary. Pass-through services do not require authorizations and can be provided without contact with Magellan.

Magellan has an established quality monitoring process for verbal appointment requests. This process was implemented in March 2012. Three calls per month are reviewed for each Member Service Representative and Care Manager using a call monitoring system (i.e., Qfiniti). The system allows supervisors to observe the audio and visual (i.e., computer entry) components of the call. Supervisors then measure staff against established performance standards; including ensuring appointments were accurately classified according to clinical urgency. If a staff member inappropriately classifies an appointment, it is addressed during the supervision process. The results of the internal monthly audits are shared with individual staff and deficiencies are addressed and monitored via the supervision process. Results are also reviewed as an aggregate as part of Magellan's quality committee structure. Aggregate results are disseminated to the Member Services and Utilization Management Committees to determine if systematic opportunities for improvement are identified.

B. **Indicator 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. See Indicator one for details on classification of appointment. This measure uses Six Sigma methodologies. Six Sigma methodology is a measurement-based approach that focuses on process improvement and variation reduction. Six Sigma describes quantitative, statistical representation of how a process is performing. To achieve Six Sigma, a process must not produce more than 3.4 defects per million opportunities in order to achieve Six Sigma. A Six Sigma defect is defined as anything outside of customer specifications, in this case members who do not receive a service within established timeframes. Each indicator includes a sigma level from zero to six, with six showing the highest level of compliance. Increases in sigma level are considered improvements.

C. **Indicator Three:** The Louisiana Unit utilizes the Magellan Member Experience of Care Survey to collected data on 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. Youth and adult versions are used to address the unique needs of the each population subset. The survey responses are based on a balanced scale with a neutral middle for most questions.

The sampling approach included all members that received services during the selected sample period, minus those that have been previously surveyed by Magellan within the same year. Eligible clients need to meet the following criteria:

- Adult Group - age 18 or older and Youth Group – under 18 years of age as of sample frame dates;
- Are an enrollee in a state Medicaid program; and
- One or more claims or have one or more authorizations to either mental health services or substance abuse services during the time period of the sample selection.

In 2014, all clients who requested treatment between time parameter (07/01 - 09/30) who had not been surveyed during the previous twelve months were selected for the sample. To meet the acceptable statistical requirements for a Power of .80 and a precision level of 95% confidence interval with a margin of error of +/- 5 percent, at least 385 respondents were required. An assumption of approximate 15 percent response rate was used to complete the calculation of the sample. Results were calculated and analyzed by the Magellan national survey department to ensure statistical validity and reliability of the results. The response rate for the contract year three administration was 13.0% (n=573), which was a slight improvement from the contract year two response rate of 12.6% (n=556). The 2014 response rate met the statistical requirements for a valid sample size.

Data for the remeasurement period were collected using a mail-out and mail-back methodology. The first mailing (12/18/2014, 12/19/2014) included the cover letter prepackaged with the client satisfaction questionnaire, and a business reply envelope. Approximately 21 days after the first mailing, a second mailing (01/8/2015, 01/9/2015) with a follow-up letter along with another client satisfaction questionnaire and a business reply envelope was sent to those clients who had not yet responded with a completed questionnaire or by means of returned mail. The survey response period was closed approximately 30 days after the second mailing (02/9/2015, 02/10/2015). Results were calculated and analyzed by the Magellan national survey department to ensure statistical validity and reliability of the results.

D. Indicator Four: Magellan defines a grievance as an *expression of dissatisfaction about any matter other than an action*. 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 web-based Complaint and Resolution Tracking (CART) system for quality management purposes. Magellan resolves each grievance individually; however, data generated by the grievance management system is also used to identify and address any trends or patterns in use or misuse of services, such as a disproportionate number of an individual type of grievance or a high or increasing number of grievances related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the appropriate committee conducts a root cause analysis and recommends interventions.

3. Project Timeline

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

1. Barrier Analyses

Barriers affecting appointment access include:

A. Member Barriers

- Member unaware of access standards
- 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

B. Provider Barriers

- 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

C. Magellan Barriers

- There is not sufficient network access to meet appointment standards.
- Magellan does not obtain information from providers regarding current availability.

3. Interventions Planned and Implemented

Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
Grievance Interventions	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.	A	QI and Network	March 2012 and ongoing	Established
	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 Louisiana Unit, an initiative will be formed to decrease the level of grievances.	A	Grievance Coordinator	July 2013	Established
	Contact providers and discuss appointment access standards when member grievance regarding access to care is received.	A	Grievance Coordinator/Network	7/2013 and ongoing	Established
Provider Access Interventions	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.	B	Network/Member Service/Clinical Staff	6/2013 and ongoing	Established
	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.	B	Network Administrator	11/2013	Established
	Implement a 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	B	Member Service Supervisor/QI Manager	6/2013 and ongoing	Established

	provider discussing expectations and requesting planned actions to comply with appointment access standards.				
	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.	B	Network Administrator	12/2013	Established
Member Access Interventions	Member Services Representatives will assist members who contact Magellan seeking assistance in obtaining appointment; outpatient support specialists and/or care managers will assist member in securing appointment within established timeframes depending on need (e.g., emergent, urgent, routine).	A, C	Member Service Staff/Care Manager	6/2013 and ongoing	Established
	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.	A,C	Member Service Staff/ Supervisor	6/2013 and ongoing	Established
TGH	Assist in the expansion of the youth residential system in partnership with Seaside Healthcare. There is expected to be 15 additional Therapeutic Group Homes in the network by November 2015. This includes 5 homes in New Orleans, 4 homes in Baton Rouge, 4 homes in Shreveport, and 2 homes in Lafayette.	C	Network Administrator	10/2014-11/2015	Established
Ad Hoc Interventions	Analyze network composition regularly through review of ad hoc reporting. Recruitment efforts will be initiated in areas where frequent ad hocs are completed due to lack of network availability.	C	Network Administrator	6/2015-ongoing	New
	Any time our ad hoc agreements increase by more than 25% within Louisiana or there is a significant increased trend in ad hoc agreements over a 2 month time period, Magellan will initiate recruitment activities.	C	Network Administrator	6/2015-ongoing	New
	If there are multiple ad hocs agreements for a specific provider, Magellan will reach out to attempt to recruit the provider.	C	Network Administrator	6/2015-ongoing	New

Adding New Services	Magellan will work with credentialed providers to add new services to existing contracts as requested.	C	Network Administrator	6/2015-ongoing	New
Systems Barrier Reporting	Developed standardized reporting process for agency partners, members, and providers to identify system barriers, included barriers related to access to care. Magellan reports issues to a monthly joint DCFS/OJJ/OBH meeting that reviews data and determines action steps.	C	Quality Management Administrator	11/2014 - ongoing	New
Independent Assessment/ Community-Based Care Management (IA/CBCM) for Adults	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. As part of the process, IA/CBCM informs members what services are available to them and helps them navigate system to ensure needs are met. The IA/CBCM is available throughout the year if the member requires a change in POC.	A, C	Adult Systems Administrator	June 2014-October 2014	New
	A random selection of high volume providers is chosen quarterly for review of the process outlined in the TRR intervention. A sample of 385 members is reviewed annually in an onsite provider review. Magellan monitors if members are receiving services as indicated on their POC. It also monitors to ensure POC are updated when warranted by member's need. Providers who do not meet 100% compliance with waiver performance measures are required to submit a CAP.	A, C	QI Manager	11/ 2013	Established

	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 are reviewed quarterly to determine effectiveness of interventions and determine next steps.	A, C	QI Manager	August 2013	New

Results

- **Indicator One:** Time from request for service to authorization of service

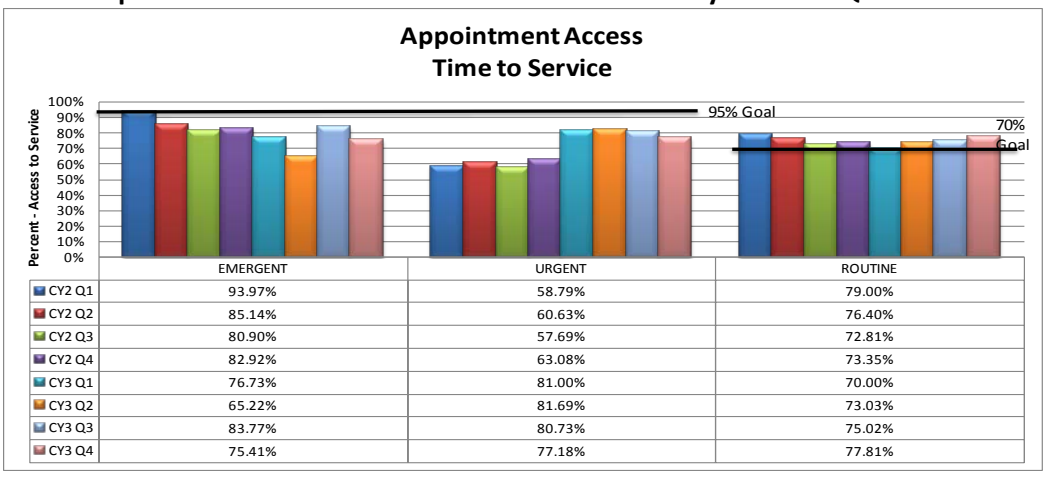
Date	Num	Denom	Emergent	Num	Denom	Urgent	Num	Denom	Routine
CY1	1,657	1,765	93.88%	15,720	16,002	98.24%	58,498	58,854	99.40%
CY2	1,523	1,693	89.96%	41,752	42,071	99.24%	64,867	65,162	99.55%
CY3	565	611	92.47%	19,921	20,278	98.24%	132,981	134,274	99.04%

- **Indicator Two:** Time from request for service to member accessing service

Contract Year 3 Data by Quarters

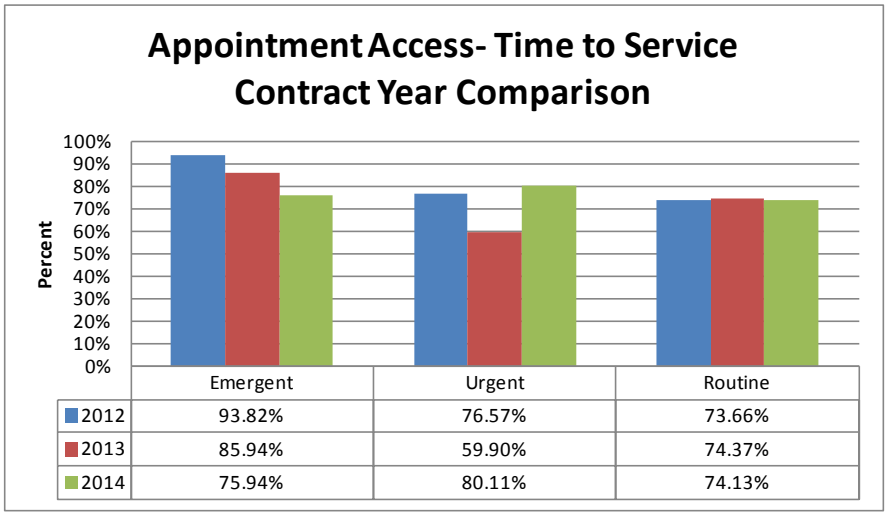
Quarters	Q1			Q2			Q3			Q4		
Metrics	Volume	Percent	Sigma Level	Volume	Percent	Sigma Level	Volume	Percent	Sigma Level	Volume	Percent	Sigma Level
Emergent	159	76.73%	2.23	115	65.22%	1.89	154	83.77%	2.48	183	75.41%	2.19
Urgent	5442	81.00%	2.38	4758	81.69%	2.40	4837	80.73%	2.37	5241	77.18%	2.24
Routine	29468	70.00%	2.02	32656	73.03%	2.11	38621	75.02%	2.17	33529	77.81%	2.27

Comparison of Contract Year 2 and Contract Year 3 by Contract Quarter



	EMERGENT	URGENT	ROUTINE
CY2 Q1	93.97%	58.79%	79.00%
CY2 Q2	85.14%	60.63%	76.40%
CY2 Q3	80.90%	57.69%	72.81%
CY2 Q4	82.92%	63.08%	73.35%
CY3 Q1	76.73%	81.00%	70.00%
CY3 Q2	65.22%	81.69%	73.03%
CY3 Q3	83.77%	80.73%	75.02%
CY3 Q4	75.41%	77.18%	77.81%

Comparison of Contract Year Data



- **Indicator Three:** Member satisfaction with access to care

Contract Year 1 through 3 Comparison of Member satisfaction with access to care – Minors

Question	% POSITIVE		
	Mar 2012-Feb 2013	Mar 2013-Feb 2014	Mar 2014- Feb 2015
Staff was willing to see my child as often as I felt was necessary.	87.0%	89.1%	88.5%
Staff returned our call(s) in 24 hours.	83.0%	86.3%	86.3%
Services were available at times that were good for us.	84.0%	85.5%	86.3%
The time my child waited between appointments was acceptable.	81.5%	84.4%	82.0%
My family got as much help as we needed for my child.	81.1%	77.6%	82.2%
My child was able to see a psychiatrist when he/she wanted to.	72.9%	75.6%	77.6%

Contract Year 1 through 3 Comparison of Member satisfaction with access to care – Adults

Question	% POSITIVE		
	Mar 2012-Feb 2013	Mar 2013-Feb 2014	Mar 2014- Feb 2015
Staff was willing to see me as often as I felt it was necessary.	79.7%	82.6%	82.9%
Staff returned my call(s) in 24 hours.	71.4%	80.9%	75.9%
Services were available at times that were good for me.	83.5%	84.2%	80.8%

The time I waited between appointments was acceptable.	79.7%	79.3%	78.6%
I was able to get all the services I thought I needed.	79.4%	78.7%	79.2%
I was able to see a psychiatrist when I wanted to.	76.1%	76.7%	71.5%

- **Indicator Four:** Member grievances regarding access to care

Contract Year	Q1	Q2	Q3	Q4	Total
1	0	1	2	4	7
2	5	5	11	22	43
3	13	5	1	0	19

Discussion

1. Discussion of Results

A. Indicator One: Time from request for service to authorization of service

Indicator one metrics show high compliance rates for urgent and routine, with rates just below the goal for emergent. Routine far exceeds the goal of 70% with a 99.04% compliance rate in contract year three. Emergent access increased in contract year three over 2.5 percentage points from the previous year.

B. Indicator Two: Time from request for service to member accessing services

Routine appointment access has consistently met the established goal of 70% and showed increasing sigma levels, indicating a statistical representation of improvement. Urgent and emergent metrics showed decreases from contract year one. Emergent appointment access was 14.49 percentage points below the established goal of 95% in the fourth quarter of contract year three. Although urgent appointment access remains below the goal of 95%, there was notable improvement with 22.4% increase from contract year two, quarter four to contract year three, quarter four.

C. Indicator Three: Member satisfaction with access to care

Four of the five satisfaction survey elements on the minor survey exceeded the 80% threshold. The element that did not meet the threshold was related to seeing a psychiatrist when desired. This was also an element below the threshold on the adult survey. Member satisfaction survey data showed opportunities for improvement related to access to psychiatrist for adults and minors. There is a

known national shortage of psychiatrists and this can even be further exaggerated for members and families living in rural areas. To address this, Magellan has established interventions to assist members in locating a provider. When members contact Magellan to access services, they are assisted to find a provider. If no providers are accessible, Magellan implements ad hoc interventions to ensure access. Magellan also utilizes physician extenders who are also able to prescribe medications. Two of the six measures on the adult survey met the minimum threshold. Besides seeing a psychiatrist when desired, adults identified three other measures as opportunities for improvement, including: the time I waited between appointments was acceptable; I was able to get all the services I thought I needed; and Staff returned my call(s) in 24 hours. In contract year three, Magellan implemented the IA/CBCM process to assist adult members in accessing services to meet their needs. It is hoped that this intervention will have a positive impact on satisfaction related to access.

D. **Indicator Four:** Member grievances regarding access to care

The number of member grievances related to access received for contract year was 19, down from a total of 43 grievance regarding access in CY2. This represents a 55.8% decrease in number of grievances. Grievances continued to be handled individually and tracked and trended to identify network or provider deficiencies.

2. Limitations

In November 2015, Louisiana will shift to an integrated medical and behavioral health model and will be transitioning management of behavioral health services to specified medical plans. Because of this, credentialing new providers will discontinue beginning June 1, 2015. Although we will not be formally recruiting providers, Magellan will continue to implement project interventions to address access issues as they are identified.

Next Steps

1. Lessons Learned

When evaluating deficiencies in urgent and emergent appointments, Magellan conducted root cause analysis. It was determined that 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. In January 2014, a mechanism to monitor appointment classification was implemented for paper-based authorizations. In order to streamline authorizations requests for routine appointments [e.g., home and community based services (HCBS)],

Magellan established a process for providers to submit paper-based requests for HCBS appointments to a facsimile box. Because clinical urgency is driven by the member, it is assumed these request are for routine appointments unless otherwise specified by the provider. As part of the monitoring process, the QM and UM/CM administrators receive a bimonthly report with any HCBS (e.g., Assertive Community Services, Community Support Services, Psych Rehab Services) requests classified as urgent/emergent. The UM supervisor reviews list to determine if the authorizations were entered by a care manager assigned to process paper-based authorizations. The supervisor reviews cases with the care manager to determine if requests were classified correctly and education is given to address deficiencies. The chart below shows there was a marked improvement identified between Contract Year (CY) 2, Q4 and CY3, Q1 for urgent appointment access, which is believed to be the result of the increased monitoring.

2. System-level Changes Made and/or Planned

Although improvements have been noted in indicator monitoring access to care, it is recommended that the project continues into contract year four to address ongoing opportunities for improvement. Magellan will maintain interventions and monitoring activities through contract year four, quarters one and two, with the final report completed in quarter three. This aligns with the end of the contract. In contract year four, Magellan will actively collaborate with OBH to implement a comprehensive transition plan.

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

Project Topic

1. Describe Project Topic

Magellan, in partnership with the LBHP, identified "The number of Coordinated System of Care treatment plans (plan of care) with service authorization at first review" as the clinical Performance Improvement Project (PIP) for contract year one.

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

2. Rationale for Topic Selection

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. This topic was selected as one method to monitor the utilization of CSoC and home and community-based services (HCBS) for these at risk children.

3. Aim Statement

The aim of the PIP was to ensure that members who are enrolled in the CSoC program have authorizations and receive services prior to the first review. As part of this project, Magellan monitored both authorization data and claims data. Authorization data were used to monitor Magellan's internal processes to ensure authorizations are made within 30 days of enrollment. Magellan also monitored claims data to determine if the services were received prior to the first review and then on a continual bases.

Methodology

1. Performance Indicators

A. Indicator One: The number of CSoC members who have received an authorization for services by the first POC review

This indicator assesses the percentage of members that are enrolled for at least 30 days who have a service authorization within 30 days of the Plan of Care development.

Denominator: Total Number of members enrolled in CSoC for at least 30 days.
Numerator: Number of members who have a service authorization within at least 30 days of the Plan of Care development.

B. Indicator Two: The number of CSoC members who have received services by the first POC review

This indicator assesses the percentage of members that are enrolled for at least 30 days who have received a service within 30 days of the Plan of Care development.

Denominator: Total Number of members enrolled in CSoC for at least 30 days
Numerator: Number of members who received a service within 30 days of the Plan of Care development

C. **Indicator Three:** The number of CSoC members that receive at least one CSoC and HCBS service per month.

This indicator assesses the percentage of members that are enrolled for at least 30 days who have continued to receive at least one service per month

Denominator (1): Total Number of members enrolled in CSoC for at least 30 days.
Numerator (2): Number of members who have a received at least one CSoC service per month and the number of members who have received at least one HCBS (i.e., CPST, PSR) service per month within at least 30 days of the Plan of Care review.

2. Procedures

WAA roster data were matched against the Magellan data system (IP) to identify all CSoC children who were enrolled in CSoC for at least 30 days and 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 remeasurement and measurement timeframes were 3/1/2014 through 2/28/2015 with the requirement that all CSoC children included in the measurement period had been enrolled in a WAA for at least 30 days.

Six Sigma methodology is a measurement-based approach that focuses on process improvement and variation reduction. Six Sigma describes statistical representation of how a process is performing. To achieve Six Sigma, a process must not produce more than 3.4 defects per million opportunities in order to achieve Six Sigma. A Six Sigma defect is defined as anything outside of customer specifications, in this case members that do not receive authorizations or services within defined time parameters. Each indicator includes a sigma level from zero to six, with six showing the highest level of compliance. Increases in sigma level are considered improvements.

4. Project Timeline

Data are monitored quarterly. Baseline data were collected in the first contract year (3/1/12-2/28/13). Data were again collected for the second contract year (3/1/13-2/28/14) and 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 3/1/2014 through 2/28/2015

Intervention Implementation	See Interventions below
Analysis of Project Data	Quarterly 3/1/2013 through 2/28/2015
Submission of Final Report	5/30/2015

Interventions/Changes for Improvement

1. Barrier Analysis

Because data on authorizations show high compliance, a multi-departmental group focused data analysis on determining opportunities for improvement and conducted root cause analysis to indentify barriers to receiving services. The following barriers were identified:

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.
2. Insufficient network access in order for members to receive the required minimum of one CSoC service per month**.**
3. Providers do not have a sufficient mechanism to track service delivery to ensure that CSoC members receive at least one CSoC service per month.
4. Providers do not have clear understanding of CSoC services or 1915 (c) waiver requirements.

2. Interventions Planned and Implemented

Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
Onsite Performance Measure Monitoring	A weighted sample based on census is selected for each region's WAA is audited quarterly using the Waiver Auditing Tool. 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.	4	CSoC Data Reporting Manager	August 2013	Established
	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	4	CSoC Data Reporting Manager	August 2013	Established

	Improve Control) model to conduct barrier analysis and develop interventions. Data are reviewed quarterly to determine effectiveness of interventions and determine next steps.				
	When system performance is less than 86% for any measure, Magellan conducts further analysis to determine the cause and complete a quality improvement project, subject to the review and approval of DHH-OBH.	4	CSoC Data Reporting Manager	February 2015	New
POC Interventions	Magellan developed standardized 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)	1, 3, 4	Children's System Administrator	01/2014	Completed
	IBHA and POC are monitored by Magellan CSoC operations care management team when submitted to ensure that members' needs are addressed. When a member does not have any HCBS authorizations, Magellan provides recommendations for inclusion of HCBS services on the POC.	3, 4	UM Care Managers	01/2014 and Ongoing	Established
Improve WAA Monitoring Capabilities	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.	3	CSoC Data Reporting Manager	12/2013	Established
	Implemented WAA Scorecard that includes metrics on Percent of members receiving CSoC and HCBS to increase provider awareness.	3	CSoC Data Reporting Manager	7/2014	New
	Provide monthly detail claims report to WAA to monitor the services each member receives.	3	CSoC Data Reporting Manager	3/2014	Established
Provider Trainings	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, 4	Children's System Administrator	1/2013 and ongoing (occurs weekly)	Established
	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.	1, 4	CSoC Data Reporting Manager	1/2013 and ongoing (occurs bi-monthly	Established

	Provide trainings on Waiver Compliance as needed to enforce adherence with the goals and principles of the CSoC and DHH-OBH. (See detailed training list at the end of the report).	1, 4	Children's System Administrator	As needed	Established
Grievance Interventions	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.	2	QI and Network	March 2012 and ongoing	Established
	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 Louisiana Unit, an initiative will be formed to decrease the level of grievances.	2	Grievance Coordinator	July 2013	Established
	Contact providers and discuss appointment access standards when member grievance regarding access to care is received.	2	Grievance Coordinator/ Network	7/2013 and ongoing	Established
Provider Access Interventions	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.	2	Network/ Member Service/Clinical Staff	6/2013 and ongoing	Established
	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.	2	Network Administrator	11/2013	Established
	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.	2	Member Service Supervisor/QI Manager	6/ 2013 and ongoing	Established

	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.	2	Network Administrator	12/ 2013	Established
Member Access Interventions	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 securing appointment within established timeframes depending on need (e.g., emergent, urgent, routine).	2	Member Service Staff/Care Manager	6/ 2013 and ongoing	Established
	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.	2	Member Service Staff/ Supervisor	6/2013 and ongoing	Established

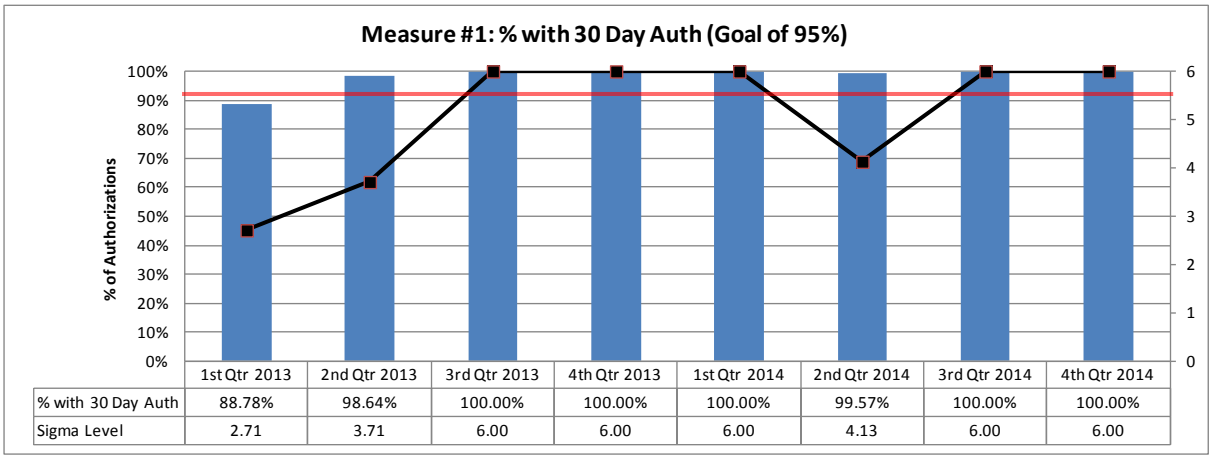
Detailed List of WAA Trainings Conduct		
Quarter	**Topic**	**Date**
FY 2013 Q4	Louisiana Changes Behavioral Health – partnership with OBH and OCDD	October 14-15, 2013
	1915(c) Home and Community Based Services (HCBS) Waiver Training Session 1: Initial Sections, Appendices A and B; Grievance and Appeals Training.	November 22, 2013
	1915(c) Home and Community Based Services (HCBS) Waiver Training Session 2: Appendices B and D.	December 17, 2013
FY 2014 Q1	1915(c) Home and Community Based Services (HCBS) Waiver Training Session 3: Appendix C; CSoC Scorecard; Trainings/Activities with Providers and Community Members	February 6, 2014
	1st Annual 1915c HCBS Waiver training conference	March 28, 2014
FY 2014 Q2	CSoC QI/QM Monthly conference call with all WAA Directors and QI Managers	May 29, 2014
	QI/QM Region 1 training Topic – " 1915c HCBS Waiver, CSoC QI data spreadsheet, PMs"	June 24, 2014
	CSoC QI/QM Monthly conference call with all WAA Directors and QI Managers	June 25, 2014
FY 2014 Q3	QI/QM Region 2 training Topic – "1915c HCBS Waiver, CSoC QI Data spreadsheet, PMs"	July 16, 2014
	CSoC QI/QM Monthly conference call with all WAA Directors and QI Managers	July 24, 2014
	CSoC QI/QM Monthly conference call with all WAA Directors and QI Managers	August 21, 2014
	CSoC QI/QM Monthly conference call with all WAA Directors and QI Managers	September 25,2014
FY 2014 Q4	CSoC QI/QM Strategic Planning workgroup call- for short and long term goals	October 13, 2014
	CSoC QI/QM Monthly conference call with all WAA Directors and QI Managers	October 23, 2014
	Regional specific calls held with Regions 1 and 2; Region 7 and Region 9 re: 1915c Waiver documentation, data collection and submission requirements; and additional technical support.	November 14, 2014
	Region specific call held with Region 8 re: 1915c Waiver documentation, data collection and submission requirements; and additional technical support.	November 17, 2014
	CSoC QI/QM Monthly conference call with all WAA Directors and QI Managers	November 20, 2014

Results

Indicators 1 and 2 for CY3

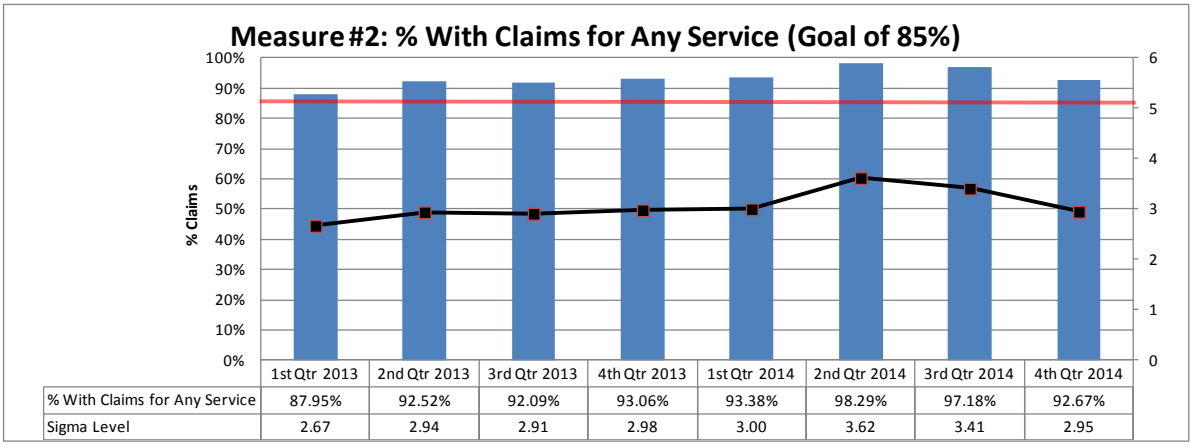
Time Period	Denominator	Numerator	% with 30 Day Auth	Sigma Level	Numerator	% With Claims for Any Service	Sigma Level
Contract Year 1	1,167	1,115	95.54%	3.2	1,049	89.89%	2.78
Contract Year 2	1,479	1,419	95.94%	3.24	1,345	90.94%	2.84
Contract Year 3	1,307	1,306	99.92%	4.67	1,254	95.94%	3.24

Indicator 1 Quarterly Rates for CY2 and CY3



	1st Qtr 2013	2nd Qtr 2013	3rd Qtr 2013	4th Qtr 2013	1st Qtr 2014	2nd Qtr 2014	3rd Qtr 2014	4th Qtr 2014
% with 30 Day Auth	88.78%	98.64%	100.00%	100.00%	100.00%	99.57%	100.00%	100.00%
Sigma Level	2.71	3.71	6.00	6.00	6.00	4.13	6.00	6.00

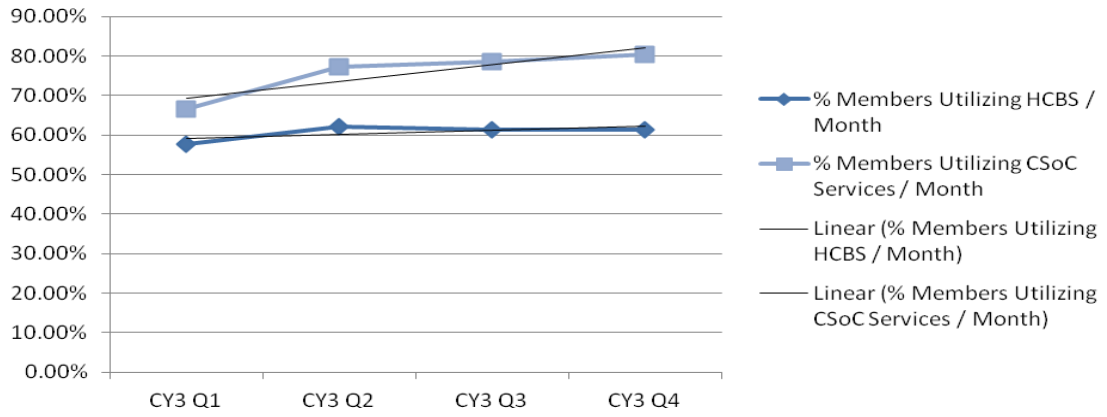
Indicator 2 Quarterly Rates for CY2 and CY3



	1st Qtr 2013	2nd Qtr 2013	3rd Qtr 2013	4th Qtr 2013	1st Qtr 2014	2nd Qtr 2014	3rd Qtr 2014	4th Qtr 2014
% With Claims for Any Service	87.95%	92.52%	92.09%	93.06%	93.38%	98.29%	97.18%	92.67%
Sigma Level	2.67	2.94	2.91	2.98	3.00	3.62	3.41	2.95

Indicators Three Rates for CY3

Time Period	Total Members	Members Utilizing HCBS	% Members Utilizing HCBS / Month	Sigma Level	Members Utilizing CSoC Services	% Members Utilizing CSoC Services / Month	Sigma Level
CY3 Q1	1322	763	57.72%	1.69	879	66.49%	1.93
CY3 Q2	1336	830	62.13%	1.81	1033	77.32%	2.25
CY3 Q3	1432	877	61.24%	1.21	1125	78.56%	2.29
CY3 Q4	1634	1004	61.44%	1.79	1314	80.42%	2.36
Contract Year 3 Aggregate	5724	3474	60.69%	1.77	4351	76.01%	2.21



Discussion

1. Discussion of Results

Magellan showed continued improvements for this project in contract year three. Magellan showed consistent high level of compliance with indicator one. In contract year three, there was a 99.92% compliance rate for enrolled CSoC members receiving service authorizations within 30 days of the POC review. The indicator obtained a sigma level of 4.67 out of 6 sigma, indicating a low level of defects in the process. The indicator for receiving a service within 30 days of the POC showed steady improvement and increased from 89.89% in contract year one to 95.94% in contract year three. This represented 6.7% increase. Both metrics exceeded the established goals of 95% and 85% established for metrics. The third indicator for continued receipt of services showed improvements as well. There was a 21% increase in members receiving at least one CSoC service per month from contract year three. quarter one to quarter four and a 6.4% increase in members receiving at least one HCBS. Both metrics showed increased sigma levels showing a statistical representation of improvement. It should be noted that the increase in the total population can be attributed to the CSoC program expanding from five to nine regions in November of 2014. The implementation of the four new WAA regions in November did not have a significant impact on established indicators one and two. Both maintained rates above the recommended goals.

2. Limitations

In contract year two, Magellan identified a limitation of the project was that it did not address the utilization of CSoC services specifically. In order to be compliant with the 1915(c) and (b3) waivers, members enrolled in wraparound services must receive at least one CSoC service per month. Magellan added an indicator to monitor if members receive CSoC and HCBS services on an ongoing basis.

A limitation of the current project is that it does not specifically address expanding access of CSoC service providers. In November 2015, Louisiana will shift to an integrated medical and behavioral health model and will be transitioning management of behavioral health services to specified medical plans. Because of this, credentialing new providers will discontinue beginning June 1, 2015. Although we will not be formally recruiting providers, the network department will continue to perform the following activities to address network access:

- Assist in the expansion of the youth residential system in partnership with Seaside Healthcare. There is expected to be 15 additional Therapeutic Group Homes in the network by November 2015. This includes 5 homes in New Orleans, 4 homes in Baton Rouge, 4 homes in Shreveport, and 2 homes in Lafayette.
- Analyze network composition regularly through review of ad hoc reporting. Recruitment efforts will be initiated in areas where frequent ad hocs are completed due to lack of network availability. Any time our ad hoc agreements increase by more than 25% within Louisiana or there is a significant increased trend in ad hoc agreements over a 2 month time period, Magellan will initiate recruitment activities. If there are multiple ad hocs agreements for a specific provider, Magellan will reach out to attempt to recruit the provider.
- Magellan will also work with credentialed providers to add new services to existing contracts as requested.

Next Steps

1. Lessons Learned

In contract year two's final report, Magellan identified the lesson learned from the project as the opportunity to improve provider (e.g., FSO, WAA, etc.) accountability to ensure members receive services timely. Magellan implemented several interventions (e.g., Improving WAA Monitoring Capabilities interventions) to increase provider accountability that appear to have been effective. These interventions will be continued into contract year four. The implementation of the four new WAA regions towards the end of contract year three went smoothly and had no significant impact on measures one and two in which both had compliance rates well above the recommended goal.

2. System-level Changes Made and/or Planned

Magellan recommends this project continue into contract year four in order to monitor indicators to ensure the improvements are maintained as the system normalizes from the expansion of the CSoC program to the entire state in November 2014. Magellan will maintain interventions and monitoring activities through contract year four, quarters one and two, with the final report completed in quarter

three. This aligns with the end of the contract. In contract year four, Magellan will actively collaborate with OBH to implement a comprehensive transition plan.

C. Transitional Care

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 transition period between care settings is a vulnerable time for patients and families. 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). 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). Transitional care (from hospital to home) is a critical component of care in behavioral health settings and should begin with the discharge facility.

Rationale for Topic Selection

The Louisiana Unit's senior clinical management and Quality Improvement Committee, in collaboration with Office of Behavioral Health (OBH) and the contracted EQRO, IPRO, identified improving transitional care after inpatient treatment as a clinical priority. Magellan initiated a performance improvement project in the second contract year (3/1/13-2/28/14) to improve 7- and 30-day ambulatory follow up visits. The ambulatory 7-day and 30-day rates showed improvement from contract year one to two, with 7-day increasing from 28% to 32% and the 30-day rate increasing from 48% to 51%. Although improvement was noted, the 7- and 30-day rates were well below the HEDIS 50th percentile for Medicaid and were identified as an opportunity for improvement. In August 2014, it was identified that enhancements to the project would be beneficial for third contract year in order to better evaluate the end-to-end discharge planning process. As a result, indicators for readmission rates, components of discharge plans, and bridge on discharge metrics were added.

3. Aim Statement

The aim of this project is to improve transitional care for members of the Louisiana Behavioral Health Partnership by ensuring that they have appropriate inpatient discharge, which will increase the likelihood of attending ambulatory follow up appointments and thus reduce the probability of readmissions into an acute setting. Magellan monitored four indicators for transitional care in order to measure improvement, including: components of discharge management planning, ambulatory follow up rates for mental health and substance use facilities, readmission rates for mental health and substance use disorders, and bridge of discharge program metrics. Indicators were evaluated by population and eligibility categories when appropriate to better target interventions.

Methodology

1. Performance Indicators

D. Indicator One: Components of Discharge Management Planning

This indicator assesses the percentage of inpatient acute behavioral health discharges with medication reconciliation and components of medication and behavioral health follow up appointments completed. Discharge summaries are also monitored and should include:

a) A plan that outlines inpatient psychiatric, medical, substance use and physical treatment and medication modalities, as applicable;
b) A list of medication records; and
c) Discharge disposition (such as specific outpatient follow up services and arrangements with treatment and other community resources for the provision of follow up services.

Denominators (5): Total number of Inpatient records reviewed as part of Magellan's treatment record reviews process for the following elements:

1. Co-occurring (co-morbid) substance induced disorder assessed.
2. Discharge plan included an appointment date and time with mental health transitioning provider.
3. Medication profile was reviewed with outpatient provider at time of transition of care.
4. Medication profile was reviewed with member at time of transition of care.
5. Discharge summary reflected the course of treatment.

Numerators (5): Records in which documentation demonstrate compliance with measure.

Note: Reviewing the medication profile must include:

1. Documentation that medications taken prior to admission were evaluated with instructions regarding continuation or discontinuation at discharge.
2. Documentation of all medications prescribed at discharge including:
    a. Drug Name
    b. Dosage
    c. Schedule

    In addition to an evaluation of home medications, a notation that the member is not prescribed any new medications at discharge is acceptable.

E. Indicator Two: Ambulatory Follow-Up Visits After Hospitalization

This indicator assesses the percentage of inpatient acute behavioral health and substance use discharges with a follow up visit within 7 and 30 days after discharge.

MH Denominator (2): Discharges (alive) from psychiatric acute inpatient stay (the principle diagnosis on the facility inpatient room and board claim is for a psychiatric ICD-9 diagnosis code). Discharge date of the stay took place during the Measurement Year (MY) (calendar year) January 1 thru December 1 of the MY; and the discharge is not followed by another inpatient (acute or non-acute) admission for any diagnosis.

MH Numerators (2): Follow up visits occurring within 7 days and 30 days after discharge, reported separately.

SUD Denominator (2): Discharges (alive) from SUD acute inpatient stay (the principle diagnosis on the facility inpatient room and board claim is for a SUD ICD-9 diagnosis). Discharge date of the stay took place during the Measurement Year (MY) (calendar year) January 1 thru December 1 of the MY; and the discharge is not followed by another inpatient (acute or non-acute) admission for any diagnosis.

SUD Numerators (2): Follow up visits occurring within 7 days and 30 days after discharge, reported separately.

F. Indicator Three: Readmissions to Mental Health and Substance Use Facilities

This indicator assesses the percentage of inpatient readmissions for mental health and substance use diagnoses.

Denominators (3): Discharges (alive) from psychiatric and SUD acute inpatient stay (authorization-based measure for outcome code 100 or 101). The other category represents unknown and medical diagnosis (UNK (Unknown) when the diagnosis code is 799.xx or <NULL>; MED for all other diagnosis codes). Reported separately and combined.

Numerators (3): Discharges resulting in re-admission within thirty (30) days

For indicators two and three, Magellan will provide data on the following eligibility categories to monitor the population differences that impact indicators:

- All Medicaid
- Adult 1915(i) Medicaid (SPMI population)
- Non-waiver Adult Medicaid
- Non-waiver Child Medicaid
- Child 1915(c) Medicaid
- Child 1915(b3) Medicaid

G. Indicator Four: Bridge on Discharge Program

1. Indicator 4A: BOD Utilization

Numerator: Discharges with a bridge visit.

Denominator: Facility discharges.

2. Indicator 4B: BOD FUH Rates

Numerator: Number of bridge visits resulting in a follow up visit (7 and 30 days, reported separately).

Denominator: Number of compliant bridge visits (Numerator from 4B).

3. Indicator 4C: BOD Readmissions

Numerator: Number of readmissions within 30 days.

Denominator: Number of compliant bridge visits (Numerator from 4B).

2. Procedures

A. Indicator One: The QM department randomly selects two to four inpatient providers monthly for participation in the Treatment Record Review process. Documentation is reviewed against quality standards for discharge planning to determine compliance. Data are collected quarterly

either via an onsite or a desktop audit. Magellan data are entered into corporate web-based auditing tool that provides aggregate and itemized reports. Magellan has a national minimum standard of 80% compliance rate for Treatment Record Reviews. The indicator goal is for all metrics to exceed the 80% minimum performance threshold.

B. **Indicator Two-MH FUH:** Data derived from a sequel-based report pulled from the Magellan Health claims database which uses HEDIS 2014 FUH claim code criteria. Long-term indicator objective is for follow up rates to meet the HEDIS 50th percentile for 7-day and 30-day goal of 46% and 65%, respectively. The annual goal is to meet or exceed 35% for 7-day combined FUH, which would represent at least a 9.3% change. The annual 30-day combined FUH goal to meet or exceed 55%, which would represent at least a 7.6% change.

Indicator Two-SU FUH: Data were derived from a sequel based report pulled from the Magellan Health claims database which uses HEDIS 2014 FUH MH methodology; however, this measure uses HEDIS SUD diagnostic codes in place of the MH ones.

C. **Indicator Three:** Metric derived from Actuate (Enterprise) Report 22A. The report is based on Integrated Product (IP) data that provide psychiatric inpatient to psychiatric inpatient readmission rates for the specified time period. Inpatient admissions that take place within 48 hours of the discharge are considered transfers and are not included in this report. Indicator goal is for the total readmission rate to not exceed 12%. The Disorder Type is determined as:
   - MH (Mental Health) when the diagnosis code is 290.xx, 293.xx to 302.xx, and 306.xx to 316.xx.
   - SU (Substance Use) when the diagnosis code is 291.xx to 292.xx and 303.xx to 305.xx.
   - Other includes UNK (Unknown) when the diagnosis code is 799.xx or <NULL> or MED for all other diagnosis codes.

D. **Indicator Four:** For indicator 4A, numerator is identified as members with a resolution code 538 indicating a BOD appointment took place. Control population includes members with discharge claim code without resolution code 538 and is matched by gender, age category, and any top 3 discharge diagnoses (799.90, V71.09 excluded). For indicators 4B and 4C, ad hoc readmission and FUH reports were developed using same methodology as indicators two and three. The BOD appointment was excluded from FUH rates.

3. Project Timeline

Event	Timeframe
Baseline Measurement Period	Indicator 1 and 4: March 2014-February 2015 Indicators 2 and 3: March 2013– February 2014

Interim Measurement Period	Quarterly January 2014 – December 2014
Submission of Interim Report (if applicable)	October 7, 2014
Re-measurement Period	Indicators 2 and 3: Quarterly March 2014-February 2015
Intervention Implementation	March 2013-February 2015
Analysis of Project Data	Quarterly March 2014-February 2015
Submission of Final Report	May 29, 2015

Interventions/Changes for Improvement

1. Barrier Analysis

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

A. Practitioner and Facility Barriers

1) Failure of facilities to discuss discharge planning in a timely manner (e.g., at the initiation of treatment).
2) Lack of facility staff and/or practitioner understanding of ambulatory follow-up standards (e.g., the use of walk-in appointments rather than establishing an ambulatory appointment with a date and time).
3) Lack of coordination of care between inpatient and ambulatory providers
4) Lack of provider availability within the appointment timeliness standards.
5) Lack of an organized screening in the MH inpatient setting for substance use disorders leading to relapse following discharge from treatment
6) Lack of medication assisted treatment for members with substance use disorders to assist with cravings leading to relapse following discharge from treatment

B. Patient-Specific Barriers

1) 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).
   - This is especially relevant for members who have had one hospitalization and no-previous behavioral health treatment and non-waiver Adult Medicaid members.
   - For the SPMI population, refusal to higher acuity outpatient services (e.g., ACT).
   - For the non-waiver population, refusal to attend any behavioral health appointments.
2) Lack of transportation to ambulatory follow-up appointments.

3) Member non-compliance with psychotropic medication because medications do not have appropriate prior authorization at time of discharge and they are unable to get prescriptions filled.

2. Interventions Planned and Implemented

Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
Monitoring of Discharge Components and Clinical Practice Guidelines for Substance Use Disorders 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 discharge planning and Clinical Practice Guidelines for treatment of Substance Use Disorders (CPG SUD).	A1, A2, A3, A6, A7, B3	QI Clinical Reviewers	March 2012- July 2015	Established
	A random sample of providers is selected monthly at 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. Members who have a diagnosis of Substance Use Disorder will be audited for the CPG SUDS.	A1, A2, A3, A6, A7, B3	QI Clinical Reviewers	March 2012- July 2015	Established
	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.	A1, A2, A3, A6, A7, B3	QI Clinical Reviewers	March 2012- July 2015	Established
	TRR data are reviewed quarterly by Magellan's Quality Improvement	A1, A2, A3,	QI Clinical	March 2012-	Established

	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 are reviewed quarterly to determine effectiveness of interventions and determine next steps.	A6, A7, B3	Reviewers	July 2015	
Provider Trainings	Provided resource documents on the Magellan of Louisiana website outlining best practices and tips for discharge planning. Discharge summary template was uploaded that addresses each of the required elements. These resources have been promoted during provider trainings as well as during onsite treatment record reviews.	A1, A2	QM Administrator	March 2014	Completed
	Conducted educational training on discharge planning during the monthly provider call. Providers were given information regarding the development of discharge plans and minimum quality standards.	A1, A2	QM Administrator	August 2014	Completed
High Readmission Inpatient Facilities Quality Meetings	Identify Inpatient providers with high readmission rates (>25%).	A1, A2	UM Administrator	May 2014	Completed
	Conducted multidisciplinary onsite quality meetings with hospital executive staff. Provider data for readmissions, follow-up rates, and ALOS were reviewed. Magellan SME's educated providers on techniques to reduce recidivism. Magellan provided education on Bayou Health formularies and how to conduct prior authorizations to ensure seamless delivery of psychotropic medications upon discharge. Educated IP providers on how to identify 1915(i) eligible members and set up appointments for eligibility screening to take place in hospital to reduce transportation barriers.	A1, A2	CMO and UM, QM, and Network Administrators	May-July 2014	Completed
	Re-evaluate data following visits to identify if improvements are identified. Conduct onsite visits of facilities that do not show improvements (readmission >25%).	A1, A2	CEO and UM, QM, and Network Administrators	October 2014	Completed
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	A3, B1, B2, B3	UM/CM Care Managers/ Follow Up Specialist	June 2013 Ongoing Quarterly	Established

	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 eligibility. Care managers identified specialized needs and implemented 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).	A2, A4, B2	Follow-Up Specialist	March 2012	Established
Improve Coordination of Care via Admissions Team (a sub-division of Magellan's Follow Up Care Management Team)	Researching claims to identify if members admitted to IP have received outpatient services. Create notes to ensure UM/CM staff have the necessary information to coordinate care (e.g., previous IP admissions, demographics, current outpatient providers etc.)	A3	Follow-Up Specialist	August 2014-Ongoing	New
	Help assist the care managers as well as the UR dept/discharge planners from the hospitals as it pertains to follow up care.	A3	Follow-Up Specialist	August 2014-Ongoing	New
	Contact ACT providers to notify them if any members currently enrolled in ACT were admitted to IP LOC.	A3	Follow-Up Specialist	August 2014-Ongoing	New
	Assisting ACT providers in locating "missing" members. (If an ACT provider has not been able to locate a client,	A3	Follow-Up Specialist	August 2014-Ongoing	New

	Magellan will call in and notify them if they have been hospitalized.)				
	Contact HCBS providers to notify them when their clients, who have current authorizations with Magellan, have been admitted to IP care	A3	Follow-Up Specialist	August 2014-Ongoing	New
	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.	B1	Follow-Up Specialist	August 2014-Ongoing	New
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 to 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 physician) 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: • Confirming demographic information with the patient and their family obtaining a current address and working phone number. • Reviewing Discharge Plan and answer any questions. • Discussing the importance of follow-up and how engagement in aftercare can reduce the chance of readmission. • Discussing the importance of taking medication as prescribed. Give suggestions that can assist with remembering medication such as a medication organizer, alarm,	A1, A2, A3, B2, B3	UM Manager/ Follow Up Specialist Manager	June 2014 Ongoing	New

	connecting with daily routine, etc. • Discussing possible barriers for keeping the appointments so that Magellan staff can work with the patient to 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.	A1, A2, A3, B2, B3	Follow Up Specialist	June 2014 Ongoing	New
	The Intervention has been implemented in a high volume IP provider (i.e., Brentwood Hospital in Shreveport). Magellan will review quality metrics of members (e.g., attendance of outpatient appointment, readmission rates) receiving BOD to determine if expansion to other providers is meaningful.	A1, A2, A3, B2, B3	UM Manager/ Follow Up Specialist Manager	October 2014 Quarterly	New
	IP utilization data and FUH rates will be analyzed to identify hospitals to expand BOD program and the network department will recruit for participation in program.	A1, A2, A3, B2, B3	QM Administrator/ Network Administrator	November 2014	New
	Implemented expanded BOD program in relevant IP facilities.	A1, A2, A3, B2, B3	QM Administrator/ Network Administrator	Contract Quarter 4 2014-15	New
UM Quality of Care Concern Reporting	UM Care Managers (CMs) work with providers during the current review process to ensure that coordination of care and discharge planning is a part of treatment. CMs asking prompting questions during each review to ensure adequate coordination of care and discharge planning is taking place in real time. If a provider is not responsive, then CMs will submit QOCCs for tracking and trending.	A1, A2, A3, A4	UM CMs	March 2012-ongoing	Established
	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	A1, A2, A3, A4	CMO and UM, QM, and Network Administrators	July 2012-ongoing	Established

	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.				

Measurements

Indicator One: Components of Discharge Management Planning

Quarter	CY3 Q1			CY3 Q2			CY3 Q3			CY3 Q4			CY3 Total		
Question	Total	% Met	Rate	Total	% Met	Rate	Total	% Met	Rate	Total	% Met	Rate	Total	% Met	Rate
Co-occurring (co-morbid) substance induced disorder assessed	163	161	98.8%	42	41	97.6%	61	60	98.4%	13	12	92.3%	279	274	98.2%
Discharge plan included an appointment date and time with mental health transitioning provider. If not, the reason was documented.	163	132	81.0%	42	30	71.4%	61	47	77.0%	13	10	76.9%	279	219	78.5%
Medication profile was reviewed with outpatient provider at time of transition of care.	163	125	76.7%	42	31	73.8%	61	55	90.2%	13	11	84.6%	279	222	79.6%
Medication profile was reviewed with member at time of transition of care.	163	149	91.4%	42	37	88.1%	61	59	96.7%	13	12	92.3%	279	257	92.1%
Discharge summary reflected the course of treatment.	163	150	92.0%	42	38	90.5%	61	59	96.7%	13	12	92.3%	279	259	92.8%

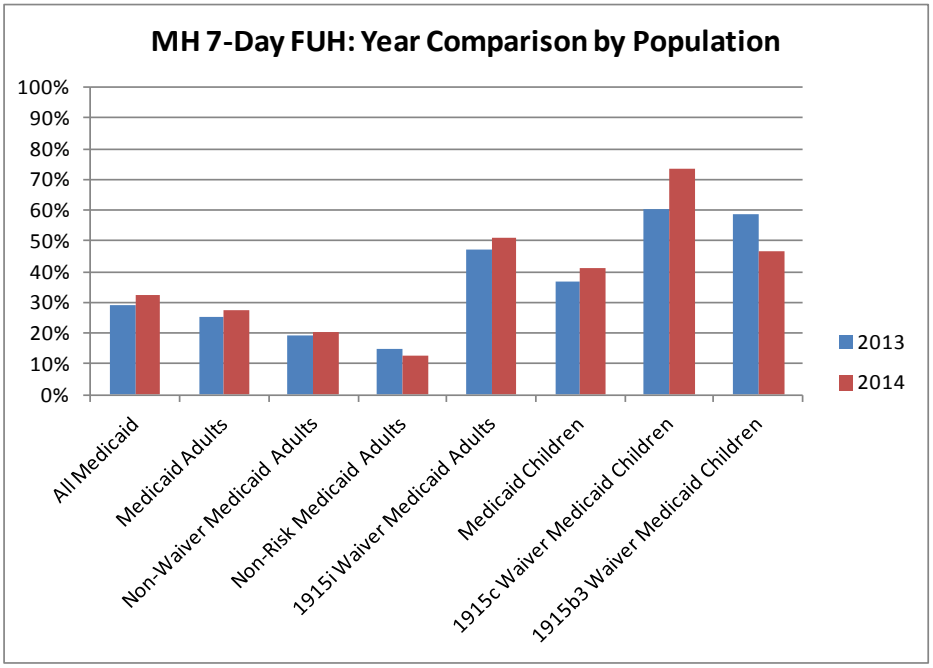
Indicator Two: Ambulatory Follow-Up Visits After Hospitalization

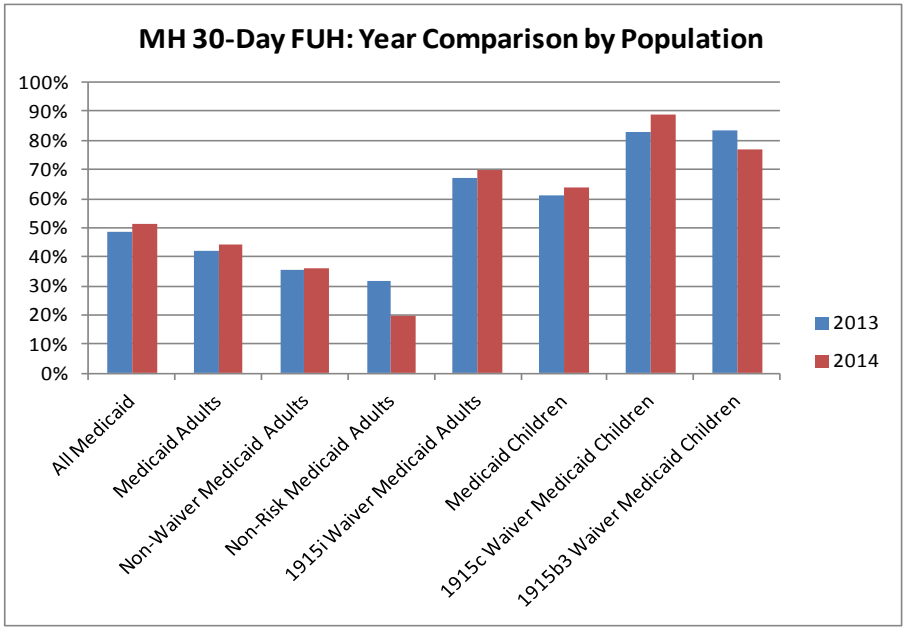
A. Mental Health

MH FUH: All Medicaid					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	16,545	4,858	29.36%	8,068	48.76%
HEDIS 2014	16,057	5,226	32.55%	8,238	51.30%
HEDIS 2014Q4	2,939	958	32.60%	1,505	51.21%
MH FUH: Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH

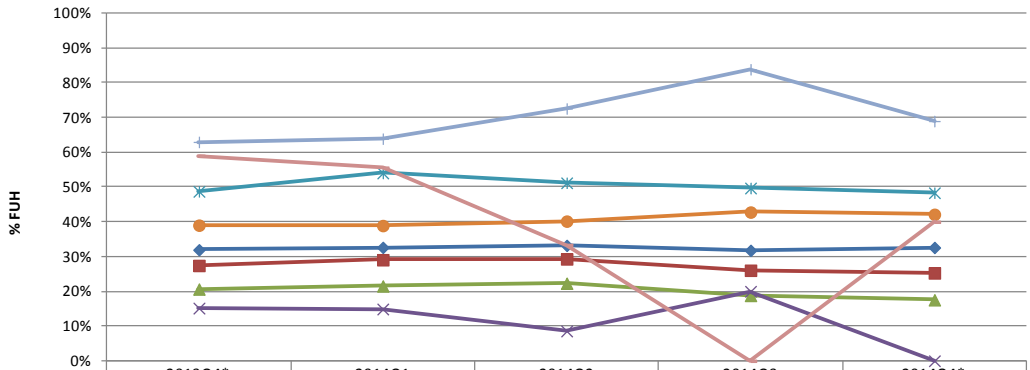
HEDIS 2013	10,675	2,696	25.26%	4,488	42.04%
HEDIS 2014	10,141	2,804	27.65%	4,459	43.97%
HEDIS 2014Q4	1,662	420	25.27%	678	40.79%
MH FUH: Non-Waiver Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	8,183	1,585	19.37%	2,883	35.23%
HEDIS 2014	7,576	1,539	20.31%	2,727	36.00%
HEDIS 2014Q4	1,231	216	17.55%	404	32.82%
MH FUH: Non-Risk Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	191	28	14.66%	60	31.41%
HEDIS 2014	116	15	12.93%	23	19.83%
HEDIS 2014Q4	9	0	0.00%	0	0.00%
MH FUH: 1915i Waiver Medicaid Adult					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	2,301	1,083	47.07%	1,545	67.14%
HEDIS 2014	2,449	1,250	51.04%	1,709	69.78%
HEDIS 2014Q4	422	204	48.34%	274	64.93%
MH FUH: Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	5,870	2,162	36.83%	3,580	60.99%
HEDIS 2014	5,916	2,422	40.94%	3,779	63.88%
HEDIS 2014Q4	1,277	538	42.13%	827	64.76%
MH FUH: 1915c Waiver Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	81	49	60.49%	67	82.72%
HEDIS 2014	218	160	73.39%	194	88.99%
HEDIS 2014Q4	58	40	68.97%	49	84.48%
MH FUH: 1915b3 Waiver Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	194	114	58.76%	162	83.51%

HEDIS 2014	30	14	46.67%	23	76.67%
HEDIS 2014Q4	5	2	40.00%	5	100.00%
*HEDIS Years and Fourth Quarter end on December 1					





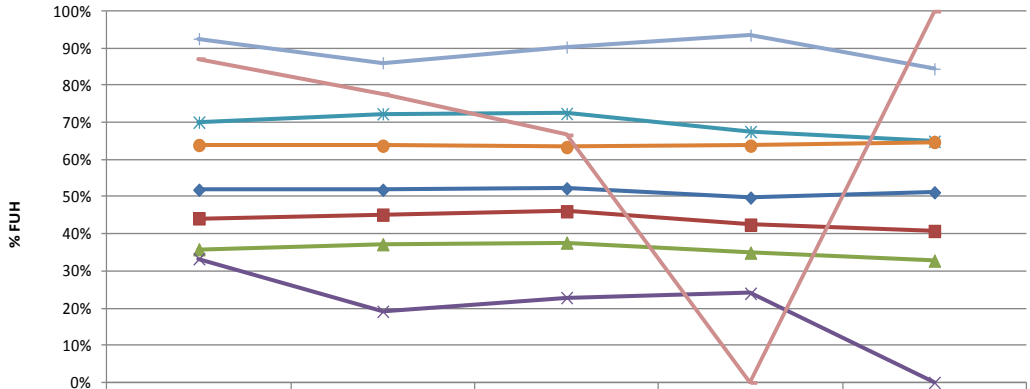
MH 7-Day FUH



	2013Q4*	2014Q1	2014Q2	2014Q3	2014Q4*
All Medicaid	31.94%	32.62%	33.19%	31.77%	32.60%
Medicaid Adults	27.42%	29.07%	29.30%	26.04%	25.27%
Non-Waiver Medicaid Adults	20.64%	21.53%	22.32%	18.80%	17.55%
Non-Risk Medicaid Adults	15.15%	14.89%	8.57%	20.00%	0.00%
1915i Waiver Medicaid Adults	48.74%	54.04%	51.20%	49.70%	48.34%
Medicaid Children	39.01%	38.90%	40.18%	42.78%	42.13%
1915c Waiver Medicaid Children	62.96%	63.89%	72.58%	83.87%	68.97%
1915b3 Waiver Medicaid Children	58.97%	55.56%	33.33%	0.00%	40.00%

*HEDIS Quarter ends on December 1

MH 30-Day FUH



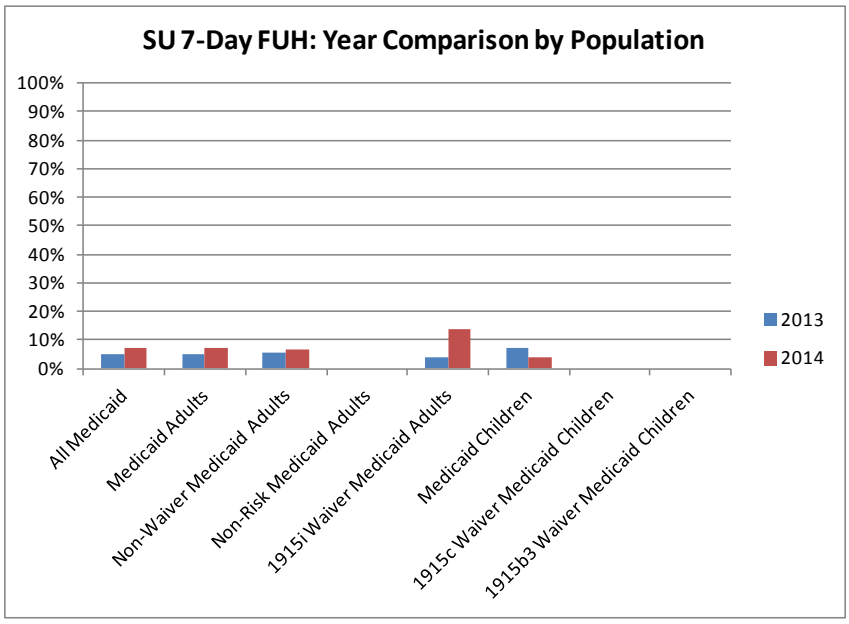
	2013Q4*	2014Q1	2014Q2	2014Q3	2014Q4*
All Medicaid	51.90%	51.89%	52.28%	49.78%	51.21%
Medicaid Adults	44.19%	45.19%	46.10%	42.50%	40.79%
Non-Waiver Medicaid Adults	35.87%	37.23%	37.66%	34.97%	32.82%
Non-Risk Medicaid Adults	33.33%	19.15%	22.86%	24.00%	0.00%
1915i Waiver Medicaid Adults	70.08%	72.36%	72.43%	67.56%	64.93%
Medicaid Children	63.95%	63.75%	63.39%	63.77%	64.76%
1915c Waiver Medicaid Children	92.59%	86.11%	90.32%	93.55%	84.48%
1915b3 Waiver Medicaid Children	87.18%	77.78%	66.67%	0.00%	100.00%

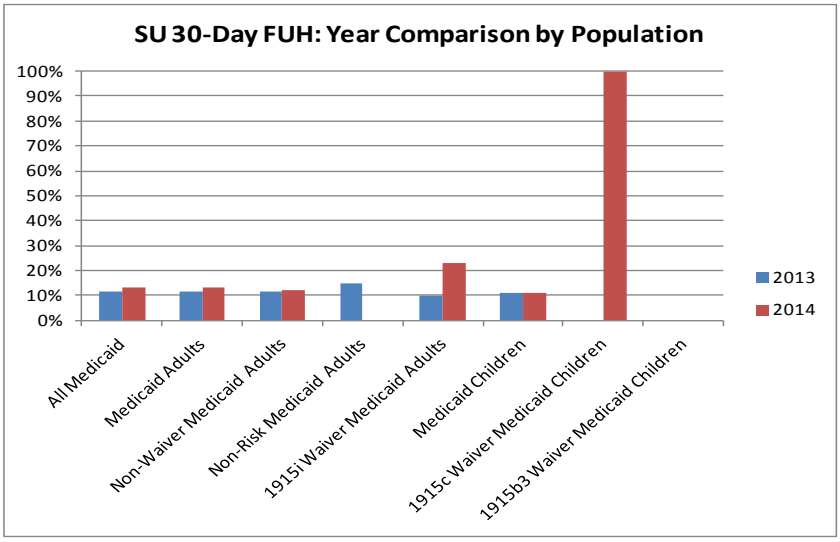
*HEDIS Quarter ends on December 1

B. Substance Use Facilities

SU FUH: All Medicaid					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	1,017	52	5.11%	115	11.31%
HEDIS 2014	946	68	7.19%	123	13.00%
HEDIS 2014Q4	166	17	10.24%	32	19.28%
SU FUH: Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	989	50	5.06%	112	11.32%
HEDIS 2014	892	66	7.40%	117	13.12%
HEDIS 2014Q4	153	17	11.11%	32	20.92%
SU FUH: Non-Waiver Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	854	46	5.39%	97	11.36%
HEDIS 2014	763	50	6.55%	91	11.93%
HEDIS 2014Q4	135	14	10.37%	26	19.26%
SU FUH: Non-Risk Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	34	0	0.00%	5	14.71%
HEDIS 2014	15	0	0.00%	0	0.00%
HEDIS 2014Q4	0	0	0.00%	0	0.00%
SU FUH: 1915i Waiver Medicaid Adult					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	101	4	3.96%	10	9.90%
HEDIS 2014	114	16	14.04%	26	22.81%
HEDIS 2014Q4	18	3	16.67%	6	33.33%
SU FUH: Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	28	2	7.14%	3	10.71%
HEDIS 2014	54	2	3.70%	6	11.11%
HEDIS 2014Q4	13	0	0.00%	0	0.00%
SU FUH: 1915c Waiver Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	0	0	0.00%	0	0.00%
HEDIS 2014	1	0	0.00%	1	100.00%
HEDIS 2014Q4	0	0	0.00%	0	0.00%
SU FUH: 1915b3 Waiver Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	0	0	0.00%	0	0.00%

HEDIS 2014	0	0	0.00%	0	0.00%
HEDIS 2014Q4	0	0	0.00%	0	0.00%
*HEDIS Years and Fourth Quarter end on December 1					



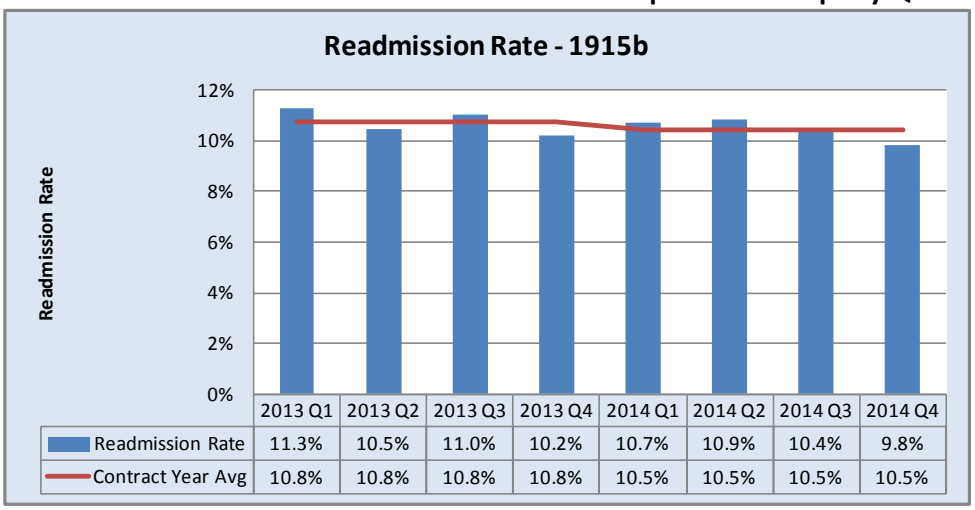


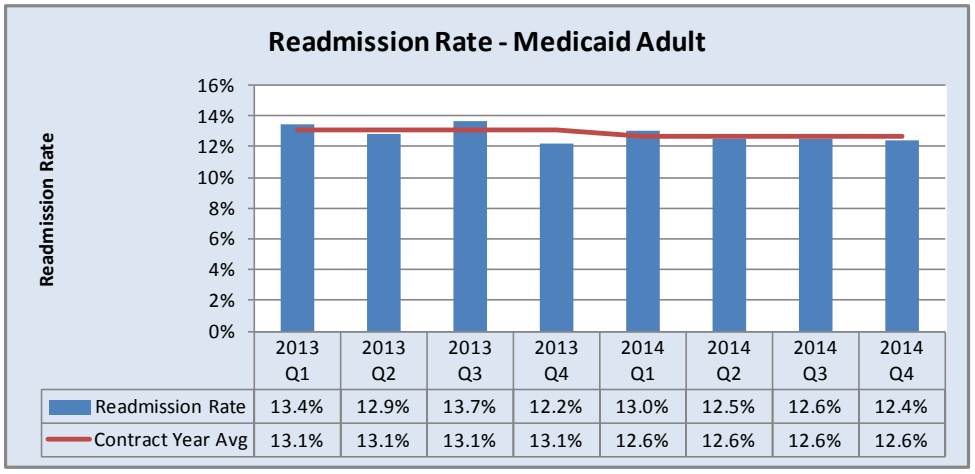
Indicator Three: Readmissions to Mental Health and Substance Use Facilities

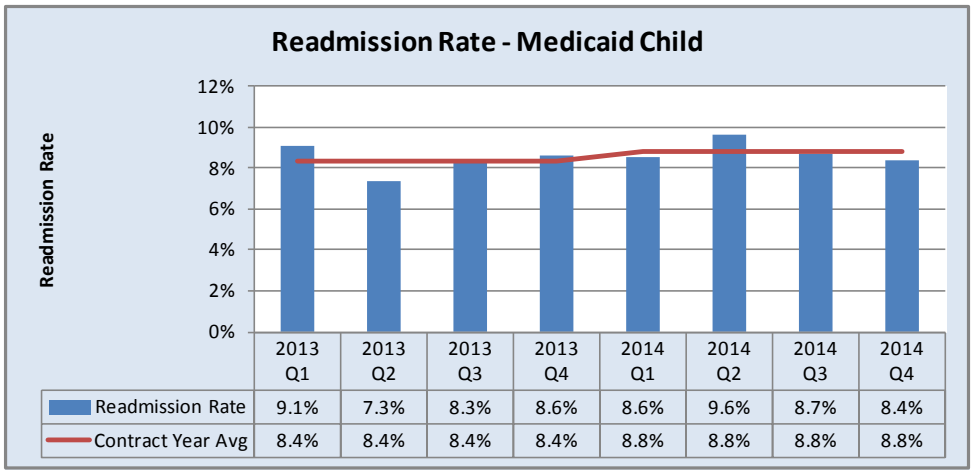
Readmissions								
All Medicaid	Total		MH		SU		Other	
	CY2	CY3	CY2	CY3	CY2	CY3	CY2	CY3
Unique Members readmitted	1,499	1,487	1,431	1,427	63	51	5	9
Total unique Discharges	18,061	18,930	16,993	17,778	918	994	150	158
Rate of readmissions	8.30%	7.86%	8.42%	8.03%	6.86%	5.13%	3.33%	5.70%
Readmissions								
Medicaid Adult	Total		MH		SU		Other	
	CY2	CY3	CY2	CY3	CY2	CY3	CY2	CY3
Unique Members readmitted	983	916	923	861	57	46	3	9
Total unique Discharges	9,966	9,758	9,073	8,781	808	859	85	118
Rate of readmissions	9.86%	9.39%	10.17%	9.81%	7.05%	5.36%	3.53%	7.63%
Readmissions								
Medicaid Child	Total		MH		SU		Other	
	CY2	CY3	CY2	CY3	CY2	CY3	CY2	CY3
Unique Members readmitted	425	452	421	448	3	4	1	0
Total unique Discharges	5,786	6,192	5,724	6,141	28	35	34	16
Rate of readmissions	7.35%	7.30%	7.35%	7.30%	10.71%	11.43%	2.94%	0.00%
Readmissions								
Non-Medicaid	Total		MH		SU		Other	
	CY2	CY3	CY2	CY3	CY2	CY3	CY2	CY3
Unique Members readmitted	128	166	121	164	5	2	2	0
Total unique Discharges	2,495	3,224	2,372	3,079	88	120	35	25
Rate of readmissions	5.13%	5.15%	5.10%	5.33%	5.68%	1.67%	5.71%	0.00%
Readmissions								
1915(i)	Total		MH		SU		Other	
	CY2	CY3	CY2	CY3	CY2	CY3	CY2	CY3
Unique Members readmitted	321	305	305	297	15	7	1	1
Total unique Discharges	1,804	1,939	1,701	1,822	91	100	12	17
Rate of readmissions	17.79%	15.73%	17.93%	16.30%	16.48%	7.00%	8.33%	5.88%
Readmissions								
1915(c)	Total		MH		SU		Other	
	CY2	CY3	CY2	CY3	CY2	CY3	CY2	CY3
Unique Members readmitted	21	29	21	29	0	0	0	0
Total unique Discharges	94	228	94	228	0	0	0	0
Rate of readmissions	22.34%	12.72%	22.34%	12.72%	0.00%	0.00%	0.00%	0.00%

Readmissions								
1915(b3)	Total		MH		SU		Other	
	CY2	CY3	CY2	CY3	CY2	CY3	CY2	CY3
Unique Members readmitted	16	2	16	2	0	0	0	0
Total unique Discharges	156	22	156	21	0	0	0	1
Rate of readmissions	10.26%	9.09%	10.26%	9.52%	0.00%	0.00%	0.00%	0.00%

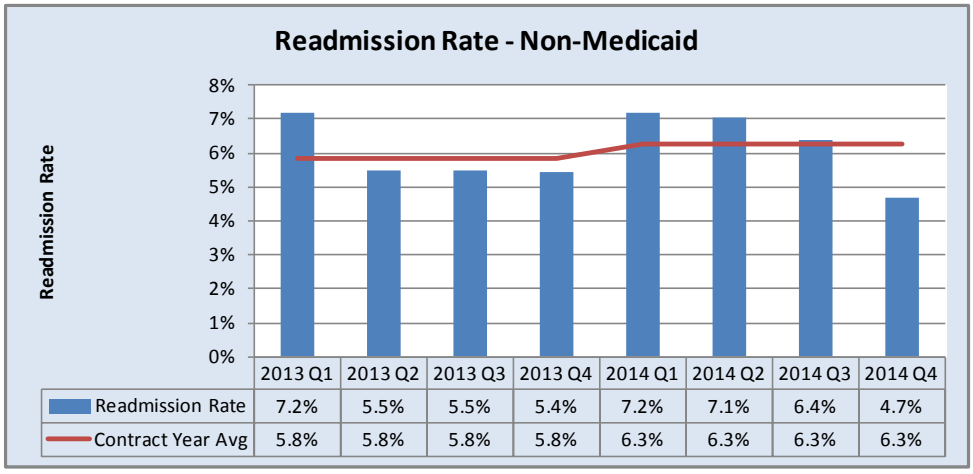
Contract Year 2013 and 2014 Readmission Rates for Population Groups by Quarter:



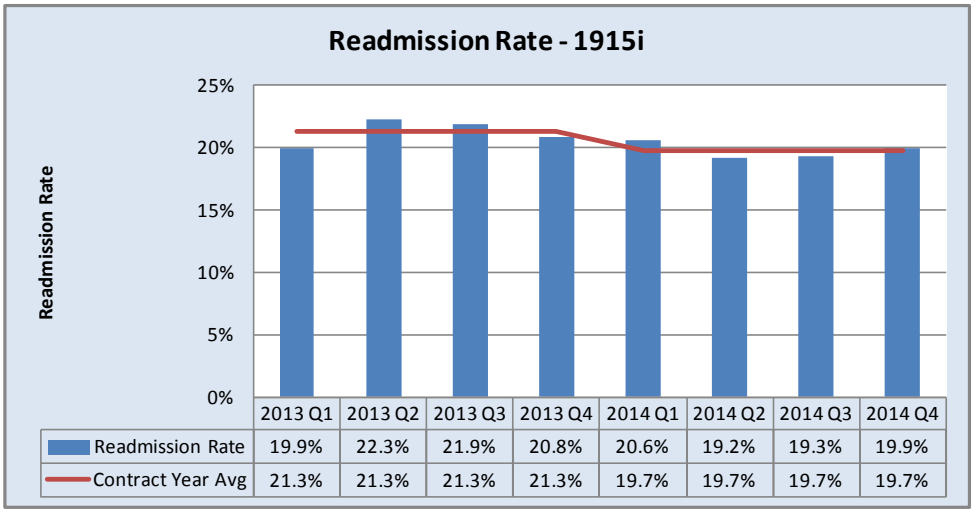




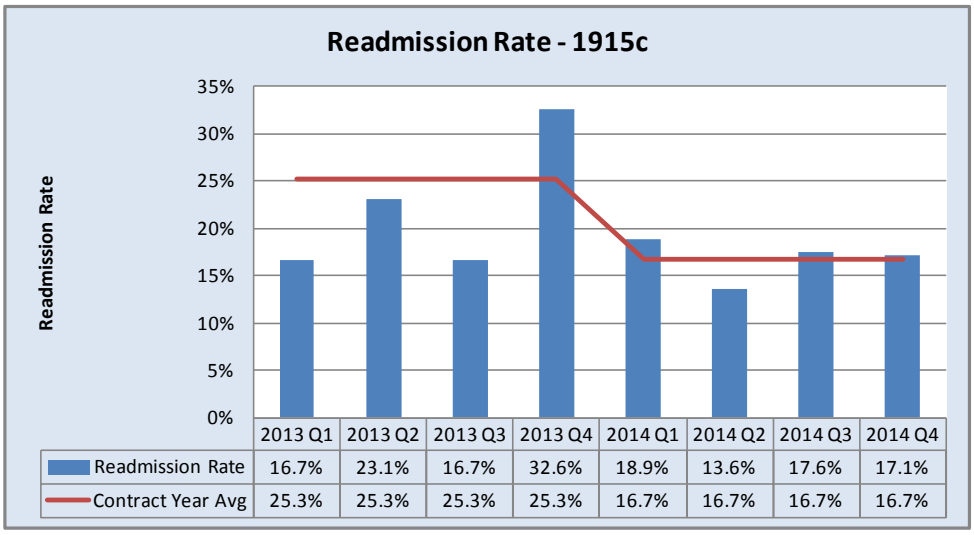
	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Readmission Rate	9.1%	7.3%	8.3%	8.6%	8.6%	9.6%	8.7%	8.4%
Contract Year Avg	8.4%	8.4%	8.4%	8.4%	8.8%	8.8%	8.8%	8.8%



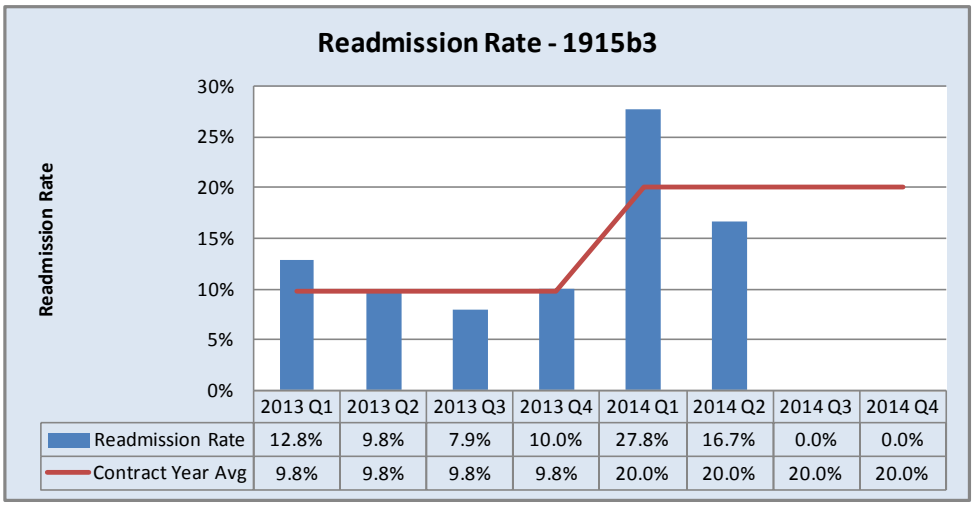
	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Readmission Rate	7.2%	5.5%	5.5%	5.4%	7.2%	7.1%	6.4%	4.7%
Contract Year Avg	5.8%	5.8%	5.8%	5.8%	6.3%	6.3%	6.3%	6.3%



	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Readmission Rate	19.9%	22.3%	21.9%	20.8%	20.6%	19.2%	19.3%	19.9%
Contract Year Avg	21.3%	21.3%	21.3%	21.3%	19.7%	19.7%	19.7%	19.7%



	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Readmission Rate	16.7%	23.1%	16.7%	32.6%	18.9%	13.6%	17.6%	17.1%
Contract Year Avg	25.3%	25.3%	25.3%	25.3%	16.7%	16.7%	16.7%	16.7%



	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Readmission Rate	12.8%	9.8%	7.9%	10.0%	27.8%	16.7%	0.0%	0.0%
Contract Year Avg	9.8%	9.8%	9.8%	9.8%	20.0%	20.0%	20.0%	20.0%

Indicator Four: Bridge on Discharge Metrics

4A: Rate of BOD Appointments

Contract Year Quarter	2014Q2	2014Q3	2014Q4
Total BOD	247	307	241
Total DCs Combined	733	923	859
Total Rate of Completion	33.70%	33.26%	28.06%
Child BOD	155	234	183
Child DCs	440	708	613
Child Rate of Completion	35.23%	33.05%	29.85%
Adult BODs	92	73	58
Adult DCs	293	215	246
Adult Rate of Completion	31.40%	33.95%	23.58%

BOD Appointments by Eligibility			
	2014CQ2 Total	2014CQ3 Total	2014CQ4 Total
Eligibility Population			
Medicaid 1915i Adult	30	19	22
Medicaid Non-Waiver Adult	60	52	36
Medicaid 1915b3 Child	0	4	9
Medicaid 1915c Child	17	16	10
Medicaid Non-Waiver Child	138	214	164
Non-Medicaid Adult	2	2	0
Grand Total	**247**	**307**	**241**

4B and 4C: BOD FUH Rates and Readmission Rates

Combined Population Clinical Metrics

Contract Year Quarter	Population	Number	Readmit % (All) Combined	FUH 7-Day % Combined	FUH 30-Day % Combined
2014Q2	Target	247	19.01%	36.84%	57.89%
2014Q2	Control	385	12.47%	35.67%	56.69%
2014Q3	Target	307	9.30%	44.40%	67.91%
2014Q3	Control	499	10.70%	40.19%	59.81%
2014Q4	Target	241	13.50%	46.57%	70.10%
2014Q4	Control	494	11.37%	33.73%	52.15%

Child Population Clinical Metrics

Contract Year Quarter	Population	Number	Readmit % (All) Child	FUH 7-Day % Child	FUH 30-Day % Child
2014Q2	Target	155	13.91%	45.31%	65.63%
2014Q2	Control	237	9.87%	44.39%	66.84%
2014Q3	Target	234	7.79%	51.67%	76.08%
2014Q3	Control	395	8.59%	44.83%	66.95%
2014Q4	Target	183	11.11%	51.88%	75.00%
2014Q4	Control	360	10.60%	40.32%	61.61%

Adult Population Clinical Metrics

Contract Year Quarter	Population	Number	Readmit % (All) Adult	FUH 7-Day % Adult	FUH 30-Day % Adult
2014Q2	Target	92	27.47%	19.35%	41.94%
2014Q2	Control	148	16.44%	21.19%	39.83%
2014Q3	Target	73	14.29%	18.64%	38.98%
2014Q3	Control	104	18.63%	20.00%	28.75%
2014Q4	Target	58	21.05%	27.27%	52.27%
2014Q4	Control	134	13.49%	14.81%	25.00%

Discussion

1. Discussion of Results

A. Indicator One: The goal is for all measures to exceed the 80% minimum performance threshold. Baseline data were gathered in contract year three and indicated that three of the five measures (i.e., co-occurring substance induced disorder assessed, medication profile was reviewed with member at time of transition of care, and discharge summary reflected the course of treatment) exceed the goal with rates greater than 90%. One measure (i.e., medication profile was reviewed with outpatient provider at time of transition of care) had an overall rate of 79.6%, which was 0.4 percentage points below the minimum threshold. The measure showed rates above the threshold in the last two quarters of contract year three. The element that showed the most opportunity for improvement (i.e., discharge plan included an appointment date and time with mental health transitioning provider) had an overall rate of 78.5%, which was 1.5 percentage points below the minimum performance threshold.

B. Indicator Two: HEDIS NCQA identify that the 50th percentile for MH FUH rates are 46% and 65% for 7- and 30-day rates respectively. In contract year three, the methodology for this metric was adjusted to meet current HEDIS Specifications. The 2014 calendar year metrics MH FUH rates for the All Medicaid population showed improvement from contract year 2013 to 2014, with 7-day rate increasing from 29.36% to 32.55% and the 30-day rate increasing from 48.76% to 51.30%. Although improvement is noted, the 7- day rate is still 13.45 percentage points below the NCQA 50th percentile for Medicaid of 46% and is 13.70 percentage points below the national average of 65% for 30 day rate. Magellan did not meet the annual goal to meet or exceed 35% for 7-day combined FUH and meet or exceed 55% for 30-day. The MH 7-Day and 30-Day FUH rates did improve for six of the eight populations, including the All Medicaid population. Medicaid Non-Waiver Adults appear to be negatively impacting overall rates. Non-

Risk Medicaid Adult population is also below thresholds; however, due to the low number of members in this category, it is not considered to impact the overall rates significantly. The following populations appear to be consistently exceeding the 46% and 65% thresholds for 7- and 30-day rates for Combined FUH measures: 1915(i) Waiver Medicaid Adult, 1915(c) Medicaid Child, and 1915(b3) Medicaid Child (YTD only).

The HEDIS 2014 SU FUH rates are lower than the MH FUH Rates but also represented a smaller number of members (n=946) compared to MH (n=16,057). The Medicaid Adult population represents the largest segment of this group and show rates lower than the MH FUH (i.e., 7-day: 7.40%; 30-day: 13.12%). Traditionally this population utilizes no traditional methods for follow-up (e.g., self-help groups) that are not captured in this claims-based metric.

C. **Indicator Three:** The goal for readmission measures is to not exceed 12% readmission rate for all Medicaid populations. The combined readmissions rate for mental health and substance use in the total for all Medicaid populations for the contract year three rate was 7.86%, which represents a slight decline from contract year two rate of 8.30%. There was a reduction in the rate for all populations except for the non-Medicaid. This group only increased by 0.02 percentage points, moving from 5.13% in contract year two to 5.15% in contract year three. A significant reduction in readmissions was seen with the 1915(c) members, which decreased by 9.62 percentage points in contract year three. The population with the highest readmission rate is the 1915(i) population, which includes high risk adult members identified with Serious and Persistent Mental Illness (SPMI). The readmission rates in this group is expected to be higher than the general Medicaid population due to acuity of the membership; however, this group also showed a reduction of 2.06 percentage points from contract year two to three with a final rate of 15.73%.

D. **Indicator Four:** The rate of BOD completion has remained steady across Q2 and Q3 implementations, with a slight decline in Q4. A majority of BOD appointments was received by children. The BOD group had a higher rate of attending 7- and 30-day FUH when compared to the control group, with the greatest impact in the 30-day rate. The BOD 30-day rate was 17.96 percentage points higher than the control group. The Q4 BOD readmission rate 2.13 percentage points lower than the control group. Readmission rates showed variability between Q2, Q3, and Q4; more data are needed to determine consistent pattern for the BOD group. The initial analysis indicates that the BOD appointment was successful in increasing the likelihood of attending a FUH ambulatory appointment. River Oaks Hospital is contracted to begin providing Bridge on Discharge (BOD) program appointments in contract year four. This will expand the program to members living in the southern region of the state.

Overall Analysis: Overall slight improvements were seen across the metrics. Readmission rates appear to be consistently below the established goal of 12% and five of the five discharge components are meeting minimum performance thresholds of 80% compliance; however, FUH rates for the All Medicaid population are below the established thresholds of 46% and 65% for 7- and 30-day FUH. When evaluating the indicators en masse, it provides meaningful insight to Magellan's approach in identifying interventions. Although FUH rates for the 1915(i) Adult Medicaid population are close to meeting the NCQA standards, the readmissions for this group is higher than any other group. Also the FUH rates for SUD are significantly lower than NCQA standards; however, this group represents the lowest rate of readmissions. This validates the importance of taking a more comprehensive approach to this PIP. It allows Magellan to focus interventions to improve specific indicators, such as implementing to High Utilizer Rounds and Substance Use Disorder Screenings in IP to improve readmissions for the 1915(i) Adult Medicaid populations and targeting interventions to Non-Waiver Medicaid Adults (e.g., Bridge on Discharge Program, UM Follow-up Team, Improve Coordination of Care via Admissions Team). Magellan is also focusing on facility interventions to improve all measures, such as Monitoring of Discharge Components and Clinical Practice Guidelines for Substance Use Disorders via Treatment Record Reviews, Provider Trainings, and UM Quality of Care Concern Reporting). The BOD Program data show that members with a BOD appointment have a higher likelihood of attending an ambulatory FUH appointment when compared to a control group; however, readmission data have shown variability, and more data are needed to determine a consistent outcome.

2. Limitations

The FUH data from previous reports were not reflective of HEDIS FUH 2014 claim code criteria and supplemental data rules. Magellan modified MH FUH to meet these requirements; however, because it is a claim-based metric, it is dependent on providers submitting their claims timely. The average claims lag is approximately 90 days, but small increases can be seen following 90 days.

Next Steps

1. Lessons Learned

BOD program has shown a positive impact on FUH rates. Even though the Adult Medicaid population has the lowest FUH rates, adults received only 28%% of the BOD appointments. Magellan worked closely with Brentwood Hospital to increase the number of adults that received a BOD appointment. They indicated the most significant barrier was related to the bus schedule. Although Brentwood is located in the northern part of the state, it provides care to members from all over the state. Because of this, they are dependent on the local bus schedule to transport members home. The bus schedule requires adults living in the southern part of the state to be discharged from the hospital before 6 a.m. to catch the bus. Alternate bus times require members to be on the bus over twenty hours and are not

reasonable for the member. Magellan will work with River Oaks to target the adult population when the BOD program is implemented.

2. System-level Changes Made and/or Planned

The following system-level changes were made in contract year three:

- Methodologies for MH FUH were adjusted to meet current HEDIS specifications. This is HEDIS-like metric as it only includes behavioral health benefits. SU FUH was adjusted to only report claims data for follow-up appointments. Combined MH/SU FUH rate was retired as it is not consistent with HEDIS Reporting.
- An "other" category was added to readmission metric. The other category represents unknown and medical diagnosis (UNK (Unknown) when the diagnosis code is 799.xx or <NULL>; MED for all other diagnosis codes).

The following system-level changes are anticipated in contract year four:

- **BOD Intervention:** One hospital (River Oaks Hospital) is contracted to provide BOD appointments and will join program in contract year four. This provider services a large volume of members in the southern regions of the state.
- Magellan will maintain interventions and monitoring activities through contract year four, quarters one and two, with the final report completed in quarter three. This aligns with the end of the contract. In contract year four, Magellan will actively collaborate with OBH to implement a comprehensive transition plan.

D. Improve Adverse Incident Reporting

Project Topic

1. Describe Project Topic

Accurate adverse incident reporting is an essential component of a quality management program that allows managed care organizations to monitor the safety culture of its providers and identify patient safety concerns that require increased oversight. Magellan is also required by contract to track, review, and investigate critical incidents and accidents, morbidities, mortalities, and other quality of care issues. When critical incidents, known as adverse incident, are received, 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, a root cause analysis is conducted and interventions are

implemented. The Quality Improvement Committee reviews this information continuously, so improvements to the system can be made on an ongoing basis. In order for this process to be effective, it is essential for providers to submit reports of incidents to Magellan.

2. Rationale for Topic Selection

According to the literature, one of the central roles of patient safety is the organization's safety culture. This safety culture defines the values and beliefs of the organization as well as how it functions (A. Kanerva *et al*. 2013). To ensure patient safety, it is important that there are not systematic weaknesses in the organization's functioning and value system (Feng *et al*. 2008). The organization must also promote patient safety as a priority (Napier & Knox 2006, Gluck 2007). Accurate adverse incident reporting is a valuable mechanism that allows managed care organizations to monitor the safety culture of its providers and identify patient safety concerns that require increased oversight.

Adverse incident reporting is also a contract deliverable for Magellan. The Request for Proposal disseminated by the State of Louisiana's Department of Health and Hospitals prescribes that the State Management Organization must:

> *Comply with all Medicaid requirements of the State Plan, 1915(b) and 1915(c) concurrent waivers, the 1915(i) State Plan Amendment, and Quality Improvement Strategy as approved by CMS including all health and welfare monitoring required to ensure enrollee safety (e.g., provider monitoring, critical incidents, medication errors, restraints, restrictive interventions, etc).*

It also states that the SMO must have:

> *Quality management staff to oversee the implementation of the Quality Management/Utilization Management Plan and to track, review, and investigate critical incidents and accidents, morbidities, mortalities, and other quality of care issues*

As the SMO, Magellan Health in Louisiana has established a comprehensive patient safety monitoring process that includes monitoring adverse incidents and quality of care concerns as well as conducting treatment record reviews and provider site visits to monitor operational and clinical practices. A key component of this process is dependent on provider reporting therefore it is essential to ensure providers are accurately reporting.

3. Aim Statement

The aim of the PIP is to show statistically significant improvement in the accuracy of adverse incident reporting as evidenced by an increase in reporting of adverse incidents especially as related to levels of care that typically have a higher rate of adverse incidents due to acuity of the members served (e.g., inpatient hospitals, PRTF, etc.).

Methodology

1. Performance Indicators

Magellan will track the following performance measures as part of this project:

1. Total number of reports received by all providers.
2. Total number of reports by inpatient providers.

2. Procedures

An adverse incident is defined as an unexpected occurrence in connection with services provided by 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.

Reporting Categories

The adverse incidents are tracked using the following categories:

1. **Death** – All deaths regardless of cause.
2. **Suicide Attempt –** The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an attempt that requires medical treatment, and/or where the member suffers or could have suffered significant injury or death.
   Non-reportable events include:
   - *Threats of suicide that do not result in an actual attempt*
   - *Gestures that clearly do not place the member at risk for serious injury or death*
   - *Actions that may place the member at risk, but where the member is not attempting harm to himself/herself*
3. **Significant Medication Error–** A significant medication error includes an incorrect medication or incorrect dosage, where a member suffers an adverse consequence and receives treatment to offset the effects of the error. Any use of medication that results in member morbidity.
   Non-reportable events include by the member to take prescribed medication

4. **Event Requiring Emergency Services** (of the fire department or a law enforcement agency) – This includes events such as fires, an individual charged with a crime, an individual who is a victim of a crime, acts of violence, vandalism, or misappropriation of member property.

   Non-reportable events include:

   - *Non-emergency services of the fire department or law enforcement agency*
   - *Police presence related to commitment procedures or rescue squad activities*
   - *Testing of alarm systems/false alarms or 911 calls by members that are unrelated to criminal activity or emergencies*

5. **Abuse** – Allegations of abuse must be reported. Abuse is occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse. Abuse includes abuse of members by staff or abuse of members by others. Depending on the nature of the abuse, it may also constitute a crime reportable to police. Abuse includes:

   A. Physical Abuse - An intentional physical act by staff or other person that causes or may cause physical injury to a member.

   B. Psychological Abuse - An act including verbalizations that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean a member.

   C. Sexual Abuse - An act or attempted acts such as rape, sexual molestation, sexual harassment and inappropriate or unwanted touching of a sexual nature of a member by another person. Any sexual contact between a staff person and a member is abuse.

   D. Exploitation - The practice by a caregiver or other person of taking unfair advantage of a member, for the purpose of personal gain, including actions taken without the informed consent of the member, or with consent obtained through misrepresentation, coercion or threats of force. This could include inappropriate access to or use of a member's finances, property, and personal services.

   Non-reportable events include:

   - *Among residents of a treatment/medical facility that may result in physical contact, but do not cause serious injury and that do not reflect a pattern of physical intimidation or coercion of a resident.*
   - *Discord, arguments or emotional distress resulting from normal activities and disagreements that can be found in a typical residential/outpatient treatment program.*

6. **Neglect** – Neglect is the failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law, contract or regulation. This can include the failure to provide for needed care such as shelter, food, clothing, personal hygiene, medical care, and protection from health and safety hazards.

7. **Injury or Illness –** Reportable injury includes those instances when the member requires medical treatment more intensive than first aid; or, anything that causes unexpected morbidity to the member secondary to the inappropriate treatment rendered. First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages. Reportable illness of a

member includes any life-threatening illness or any involuntary emergency psychiatric admission that occurs as the result of a residential provider's initiation.

Non-reportable events include:

- *Scheduled treatment of medical conditions, on an outpatient or inpatient basis*
- *Any voluntary inpatient admission to a psychiatric facility, or service at a crisis facility or psychiatric department of acute care hospitals for the purpose of evaluation and/or treatment*
- *Emergency room (ER) visits or inpatient admissions that result from a member's previously diagnosed chronic illness, where such episodes are part of the normal course of the illness*
- *ER visits where the visit is necessitated because of the unavailability of the member's primary care physician.*

8. **Missing Person** – Residential/Inpatient providers are to report a member who is out of contact with staff, without prior arrangement, for more than 2 hours. A person may be considered to be in "immediate jeopardy" based on his/her personal history and may be considered "missing" before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about a missing person, or the police independently find and return the member, regardless of the amount of time he or she was missing.
9. **Seclusion or Restraint** – Providers are to report any use of seclusion or restraint (chemical, mechanical and physical). Providers are required to report all incidents of restraint and seclusion use that result in injury within the defined Adverse Incident reporting timeframes. Restraints and seclusions that do not result in injury are tracked independently.
    - *Chemical restraints consist of one time as needed medications which restricts the freedom of movement or causes incapacitation by sedation. This does not include the use of standing PRN dosages.*

Adverse Incident Reporting

Providers are required to submit the Adverse Incident Reporting form to Magellan within 24 hours of an adverse incident occurrence. This form serves to capture any reportable incidents involving a member of the LA Behavioral Health Partnership, currently in treatment or discharged from treatment within 180 days prior to the incident.

Reporting Requirements

The following guidelines outline the timeframes in which a provider is required to report an incident to Magellan:

- For the following types of events, submit a report if the event occurs **while in the provider's care**:
    - Significant medication error, need for emergency services, serious injury or illness, missing person, seclusion or restraint.
- For the following types of events, submit a report **regardless of where it occurs**:

- Death, Suicide Attempt, Abuse, Neglect, or Exploitation.

Internal Processing of Incidents

Adverse Incident Reporting forms are faxed by providers to a Quality Improvement fax box. The Adverse Incident/ Quality of Care Clinical Reviewer monitors the fax box every business day. All adverse incidents are entered into the Quality Improvement System for tracking proposes. Each incident is reviewed and investigated to determine if there is dangerousness associated with the incident. If dangerousness is identified, all efforts are made to ensure the safety of member/s affected. The Chief Medical Officer is consulted for all serious incidents to determine an appropriate action plan (e.g., onsite review, record review). Results of the investigation are presented to the Regional Network Credentialing Committee (RNCC), a provider peer committee. If the incident involves any of our state partners (e.g., Department of Children and Family Services and/or the Office of Juvenile Justice), the state partner is notified by Magellan within 24 hours of discovery of the incident through established collaborative protocols. If the incident is severe enough, it is immediately taken to the RNCC for approval of action steps (e.g., placing provider on hold, terminating provider from network). The data are aggregated monthly and reported to the RNCC monthly and the Quality Improvement Committee quarterly. Magellan conducted analysis using the paired t-test to determine if statistically significant improvement is seen between Contract Year 2 and Contract Year 3 for total number of reports received by all providers and total number of reports by inpatient providers.

3. Project Timeline

Data is monitored quarterly. Baseline data was collected in the second contract year (3/1/13-2/28/14). Re-measurement data will be collected for the third contract year (3/1/14-2/28/15).

Event	Timeframe
Baseline Measurement Period	3/1/2013 through 2/28/2014
Interim Measurement Period	Quarterly 3/1/2014 through 2/28/2015
Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Quarterly 3/1/2014 through 2/28/2015
Intervention Implementation	See Interventions below
Analysis of Project Data	Quarterly 3/1/2014 through 2/28/2015
Submission of Final Report	6/30/2015

Interventions /Changes for Improvement

1. Barrier Analysis

Barriers affecting provider reporting of adverse incidents includes:

1. Providers unaware of reporting process.

2. Providers are aware but are not reporting as required.
3. Providers report incidents to DHH or other regulatory entity but do not report them to Magellan.
4. Providers are not aware of adverse incident definitions.

2. Interventions Planned and Implemented

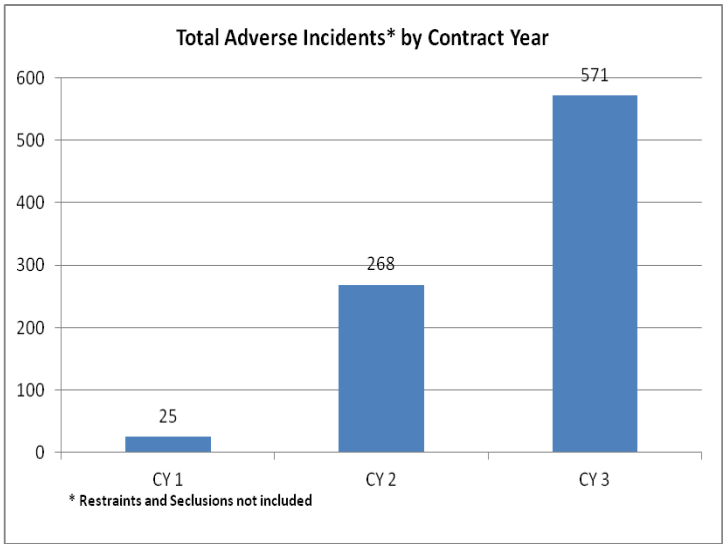
The initial interventions in the chart below are focused on taking a collaborative and educational approach with providers to address the barrier that providers are unaware of the reporting requirements or are not reporting. Later interventions become more punitive when the barriers indicate that providers are aware but are choosing not to report. The interventions (except the treatment record review) are based on provider integrity as they require self reporting.

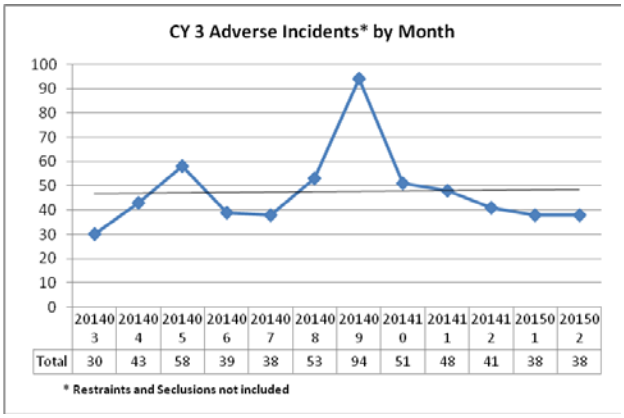
Category	Intervention	Barrier	Responsible Party	Date of Implementation
Provider Trainings Interventions	Include the Critical Incident reporting requirements in Provider Orientation Training	1,4	Network Trainer	October 2014, ongoing
	Conduct network refresher trainings to ensure providers are aware of reporting requirements, procedure and definitions.	1,4	AI/QOC Coordinator	October 2014
Treatment Record Reviews	Add an element on the TRR auditing tool to track if AI protocol was used if adverse incident is documented in record.	1,2,3,4	QI Reporting Manager	9/30/2014
	Conduct internal training of Clinical Reviewer staff to ensure consistent understanding of Critical Incident Definitions and provide training on the scoring guidelines for new AI TRR auditing item.	1,2,3,4	AI/QOC Coordinator	9/30/2014
	Random sample of records from providers from all LOCs are requested monthly (beginning in 3/2015 high volume providers will be reviewed once every 2 years) is selected.	1,2,3,4	QI Manager	November 2014
	Magellan will review records using TRR Auditing Tool. If critical incident is identified, then Magellan will coordinate with AI/QOC coordinator to ensure it was reported through established process and score TRR item appropriately.	1,2,3,4	QI Clinical Reviewers; AI/QOC Coordinator	November 2014
	If provider did not report, AI/QOC coordinator will determine if provider has a reporting history.	1,2,3,4	QI Clinical Reviewers; AI/QOC Coordinator	November 2014
	If provider has no previous history of interventions, CR will provide education and request provider to sign attestation stating that they understand and will adhere to Magellan' critical incident reporting protocol.	1,2,3,4	QI Clinical Reviewers	November 2014
	If provider has a history of previous	2,3	QI Clinical Reviewers	November 2014

	interventions, corrective action plan will be required that will be monitored by the Regional Network Credentialing Committee.			
	If provider is not responsive to Corrective Action Plan (CAP), the RNCC will determine next steps (e.g., placing provider on hold from accepting new members, termination) based on review of actions.	2,3	CMO	January 2015
Grievances and Quality of Care Interventions	Magellan will review all reports submitted through the grievance and quality of care process.	1,2,3,4	Grievance Coordinator; AI/QOC Coordinator	October 2014
	If a critical incident is identified, Magellan will review critical incident data to determine if report was submitted by the involved provider using the established protocol.	1,2,3,4	AI/QOC Coordinator	October 2014
	If provider has no previous history of interventions, CR will provide education and request provider to sign attestation stating that they understand and will adhere to Magellan' critical incident reporting protocol.	1,2,3,4	AI/QOC Coordinator	October 2014
	If provider has a history of previous interventions, corrective action plan will be monitored by the Regional Network Credentialing Committee.	2,3	AI/QOC Coordinator	October 2014
Inpatient Monitoring Interventions	Establish monthly report (based on authorization data) of the number of members served in inpatient acute settings.	1,2,3,4	AI/QOC Coordinator	October 2014
	Compare utilization data to the number of adverse incidents reported.	1,2,3,4	AI/QOC Coordinator	October 2014
	Identify providers that have served over 25 members and have not reported a critical incident.	1,2,3,4	AI/QOC Coordinator	October 2014
	Provide education to hospitals with 25 members and no reporting history and request provider to sign attestation stating that they understand and will adhere to Magellan' critical incident reporting protocol.	1,2,3,4	AI/QOC Coordinator	October 2014
	Track and trend data to see if providers who were not reporting initiated report submissions using the above protocol.	2,3	AI/QOC Coordinator	January 2014
	If improvements are not identified (e.g., no critical incidents are received in one month), then an individual provider training will be conducted to review the provider's policies and procedures for tracking and reporting adverse incidents. This intervention, includes: 1. Meeting with risk manager 2. Reviewing aggregate critical incident data for the facility 3. Reviewing current utilization data 4. Identifying if there are barriers to reporting 5. If a low number of aggregate incidents	2,3	AI/QOC Coordinator	January 2014

	for the total population served are identified, Magellan will reinforce reporting procedure and get signatures to validate training took place. 6. If high number of aggregate incidents for the total population served is identified, the provider will be placed on corrective action plan requiring them to respond on how they will improve reporting.			
	Track and trend data to see if providers who were not reporting initiated report submissions using the above protocol.	2,3	AI/QOC Coordinator	February 2014
	(For those providers not on corrective action plan): if improvement is not indicated once onsite audit is completed, the provider will be placed on corrective action plan that will be monitored by the Regional Network Credentialing Committee.	2,3	AI/QOC Coordinator	December 2014/ January 2015
	If provider is not responsive to Corrective Action Plan (CAP), the RNCC will determine next steps (e.g., placing provider on hold from accepting new members, termination) based on review of actions.	2,3	CMO	January 2015

Results




CY 3 Adverse Incidents* by Month
100
90
80
70
60
50
40
30
20
10
0
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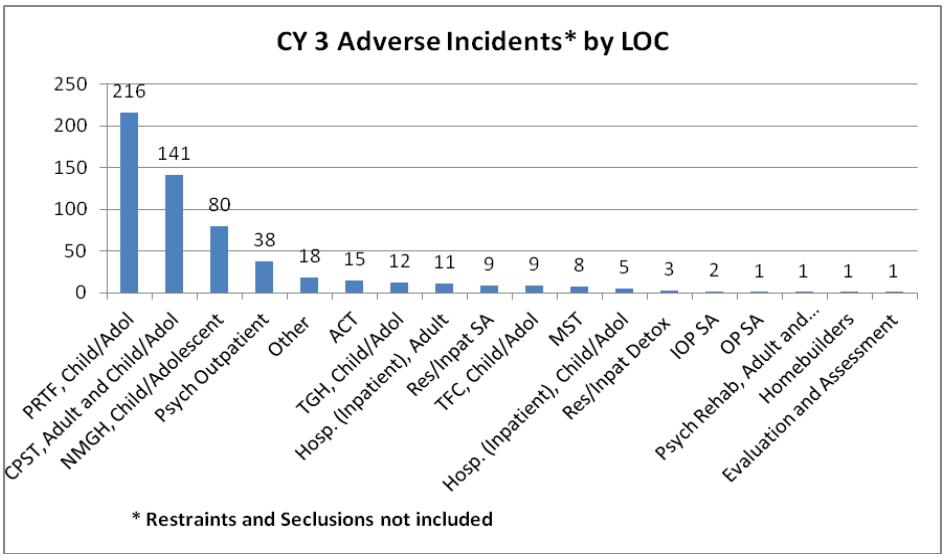
Total 30 43 58 39 38 53 94 51 48 41 38 38
* Restraints and Seclusions not included


CY 3 Adverse Incidents* by LOC
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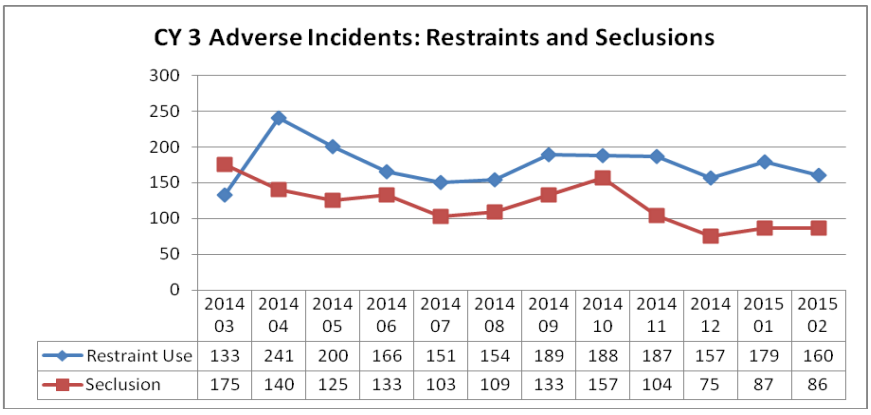
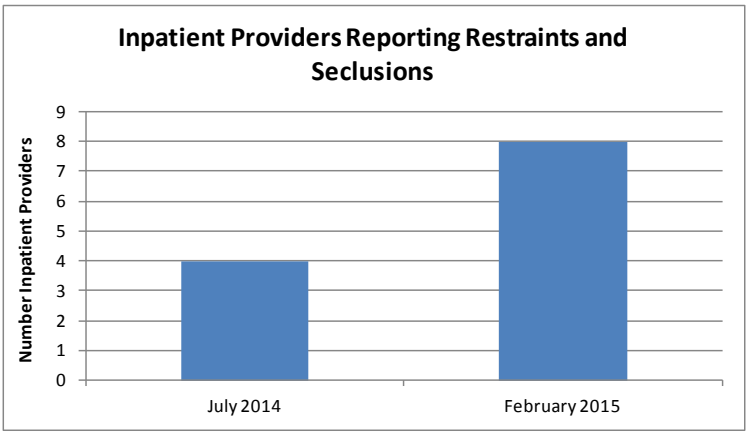
200
150
100
50
0
216
141
80
38
18
15
12
11
9
9
8
5
3
2
1
1
1
1
PRTF, Child/Adol
CPST, Adult and Child/Adol
NMGH, Child/Adolescent
Psych Outpatient
Other
ACT
TGH, Child/Adol
Hosp. (Inpatient), Adult
Res/Inpat SA
TFC, Child/Adol
MST
Hosp. (Inpatient), Child/Adol
Res/Inpat Detox
IOP SA
OP SA
Psych Rehab, Adult and...
Homebuilders
Evaluation and Assessment
* Restraints and Seclusions not included


CY 3 Adverse Incidents: Restraints and Seclusions
300
250
200
150
100
50
0
201403 201404 201405 201406 201407 201408 201409 201410 201411 201412 201501 201502
Restraint Use 133 241 200 166 151 154 189 188 187 157 179 160
Seclusion 175 140 125 133 103 109 133 157 104 75 87 86



Discussion

1. Discussion of Results

Reports of adverse incidents increased from 268 in contract year two to 571 in contract year three, which represents a 113.1% increase. There was an average of 45 reports per month in contract year three compared to 20 in contract year two. This represents a statistically significant improvement (p=0.0003). Magellan utilized paired t-test to analyze statistical significance of change. The top three LOCs (i.e., PRTF, CPST/PSR, and NMGH) accounted for 76.5% of the reported Adverse Incidents. This does not include restraints and seclusions. Magellan has seen an increase in the number of inpatient providers reporting restraints and seclusions. Prior to implementation of PIP, there were only four inpatient providers reporting. By the end of contract year three, the number doubled to eight providers. Despite the increase, restraints and seclusion reports have trended downward. This indicates that providers that were previously reporting have seen a reduction in reportable restraints and seclusions.

2. Limitations

There is currently no mechanism to compare adverse incidents reported for the Medicaid population in Louisiana to other states. Despite reaching out to national subject matter experts (i.e., Building Bridges Initiative) as well as corporate subject matter experts, a mechanism to compare Louisiana to a national average or rate was not identified. In contract year four, Magellan will implement enhanced reporting to try to address these limitations. In contract year four, Magellan will add a measure to the PIP to comparing Louisiana's incidents of suicide and homicides to national averages, which is established through the Center for Disease Control and Prevention (CDC).

The overall age-adjusted suicide rate in the United States was 12.6 per 100,000 in 2012. In calendar year 2014, the rate of suicide for the Medicaid eligible population for Louisiana was 0.69 per 100,000 and the rate for suicide for the members served was 5.94 per 100,000. These are both below the CDC overall age-adjusted rates for the United States. The overall age-adjusted homicide rate in the United States was 5.2 per 100,000 in 2013. In calendar year 2014, the rate of homicide for the Medicaid eligible population for Louisiana was 0.48 per 100,000 and the rate for homicide for the members served was 4.12 per 100,000. These are both below the CDC overall age-adjusted rates for the United States.

Resource: http://www.cdc.gov

Next Steps

1. Lessons Learned

Many providers felt it was unreasonable to request that they report incidents using a standardized form. Providers, especially inpatient providers, are already required to report adverse incidents to DHH and accrediting bodies, and many have their own standardized process for reporting. Requiring a standardized form creates an unnecessary burden to providers and reduces the likelihood of reporting to Magellan. Because of this, Magellan discontinued the requirement of using a standardized form as long as all required elements are reported. The standardized form is still available for use by providers who do not have their own reporting form.

2. System-level Changes Made and/or Planned

Magellan will maintain interventions and monitoring activities through contract year four, quarters one and two, with the final report completed in quarter three. This aligns with the end of the contract. In contract year four, Magellan will actively collaborate with OBH to implement a comprehensive transition plan. Magellan will also implement enhanced reporting of adverse incidents to DHH-OBH. The following modifications will be made to reporting:

- Magellan will provide a monthly report of restraints and seclusions by provider. Magellan will track and trend report to identify if significant overutilization of restraints or seclusions are identified. If overutilization is indicated (significant increase use of restraints and seclusions), then Magellan will provide action steps taken by provider to address.
- Magellan will provide details on any member that meets or exceeds a threshold of 3 or more elopements per month. Magellan will also report if a provider meets or exceeds total

of five or more elopements per month. Report will include name of provider, number of elopements, and action steps taken by provider to address.

- Magellan will track Louisiana's incidents of suicide and homicides compared to national averages.
- Magellan will submit a detailed monthly report for incidents of deaths, serious incidents, and abuse. The report will identify action steps taken to address and the status of the incident. This will include details on investigations conducted by the provider and/or Magellan for abuse reports.
- Magellan will report if a provider meets a threshold of more than 2 reports of death or suicide during a three month period.

VI. Care Management Initiatives

The Magellan Care Management/Utilization Management Program ensures that treatment services for the member are fully coordinated across the entire service delivery system. This includes ensuring the member has access to support services and community resources needed to fully participate in treatment. Care management services also include facilitating referrals and communication with and between providers, and coordinating care for the member across all treatment modalities. Special attention is paid to members who are discharged from inpatient care, transition-age youth, youth in CSoC, adults in facility-based substance use disorder programs, and members with co-morbid physical health and behavioral health conditions, as well as all priority populations identified by or in collaboration with OBH. Throughout the course of the member's care, the Care Manager assures that appropriate releases of information are signed and that all behavioral and physical health providers are communicating relevant information (e.g., medications).

The Care Management/ Utilization Management Program is organized to support the unique needs of members and their families through functional teams reporting to the Care Management/Utilization Review Administrator who oversees the department and also serves as the Chief Clinical Officer. The CM/UM functions are performed by CM/UM teams that include a Clinical Manager, Team Leaders, Care Managers, Care Workers and Peer Recovery Navigators or Follow-up Specialists. Functional teams also

include children and adult subject matter experts. Care Managers within each team are highly experienced and specialized in providing services to the special populations served by each team. For example, the adult CM/UM team includes clinicians with experience working with pregnant women with behavioral health needs, women with SUD substance using and have young children, persons with HIV, and IV drug users. Similarly, Care Managers serving the child/youth population have expertise working with children with behavioral health needs in contact with child serving systems but not functionally eligible for CSoC and youth in transition. All teams include clinicians with expertise in addressing the needs of members who are experiencing substance use disorders, involved with State agencies, and members with complex clinical needs.

The care and utilization management process begins at the time of the member's entry into the system and is completed when the member is fully discharged from services. It includes all functions that assist the member in participating and meeting treatment goals. The integration in the delivery of care and utilization management functions, where the same clinician fulfills both functions, is a reflection of the integrated service delivery process that we implement for each member. Within this process, the member is the focal point of all treatment services. Clinical and other services are woven around the member and are fully integrated to allow for optimal treatment outcomes. We support the member through the following care and utilization management processes:

- **Initial triage and Assessment –** Care Managers conduct an initial and brief assessment of the member's needs to determine the level of care and most appropriate services. Triage services are provided based on the level of urgency the member presents. We will ensure that members with emergency needs can access services immediately, while those with urgent and routine needs access services within 48 hours and 14 days, respectively. Members are referred to a provider of choice for a more comprehensive assessment and treatment planning. Children and adolescents who are eligible for Children System of Care (CSoC) services are referred to wraparound agencies (WAA). Adults eligible for 1915(i) services are referred to community based care managers for assessment and treatment planning.
- **Service Authorization** – Once a provider has completed the initial assessment, the provider is required to submit information for service authorization. Care Managers approve services if the treatment plan is appropriately completed.
- **Care Coordination –** Our Care Managers work with and support the WAAs and providers in ensuring that the member's care is fully coordinated across levels of care and providers. Managing this process is dependent on the member's needs.
- **Utilization Management –** Our Care Managers routinely review all levels of care against predefined UM standards to ensure the continued applicability of the treatment services to medical necessity criteria. As needed, they will work with the provider and member to offer alternative levels of care where medical necessity criteria are not met.

- **Discharge and Follow-up Planning –** Magellan Care Managers work with inpatient and residential staff to ensure that members have a fully defined discharge plan and follow up plans during their admission into an inpatient facility. The goal of discharge planning is to ensure that the member has all needed supports and services to remain within the community and home setting. The Community Intensive Care Coordination and WAA Care Managers provide this function for members enrolled in these services.

The Utilization Management Committee (UMC) is responsible for reviewing and evaluating patterns of care and key utilization indicators and reports to the QIC. During contract year three, the UMC recognized the need to mitigate outlying utilization trends for both acute inpatient hospitalization and residential substance use treatment levels of care. As a result the following four initiatives were implemented:

- Active Management of Acute Inpatient Initial Requests
- Length of Stay (LOS) clinical rounds for members in acute inpatient settings and residential LOS rounds for members in III.3-III.7 ASAM treatment settings
- High Complexity member rounds
- ACT Scorecard

These four interventions will be maintained into contract year four due to successful outcomes.

A. Active Management of Acute Inpatient Initial Requests

Historically, and in response to high volume and complex calls, our triage care management team has de-emphasized peer referrals for initial requests, since those cases require follow up, consume more time, and result in longer hold times and increased dropped calls. However, in response to the Louisiana Unit experiencing a steady upward trend in admissions, it was decided to target care manager efforts on actively managing acute inpatient requests and add physician advisor referral rates as a deliverable. Monthly referral rates from June through November 2014 are as follows:

June	July	August	September	October	November
5.2	7.1	8.0	5.7	10.9	7.6

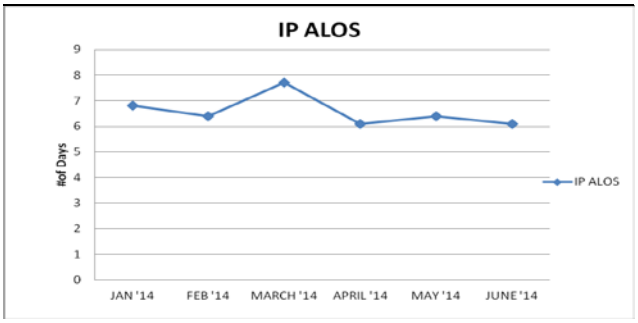
B. Acute IP and Residential Length of Stay Rounds

Each week members with acute IP lengths of stay eight days or longer or residential LOS of 20 days or longer are identified and targeted for rounds with our UM Medical Administrator. Care managers are

broken into teams with the expectation to attend rounds once weekly and be prepared to discuss all identified cases. Presentations are structured to include detailed discussions around diagnoses, admission precipitants, medication issues, medical comorbidities, social supports, substance use issues and discharge planning. Monthly ALOS results from January to June 2014 are presented below:

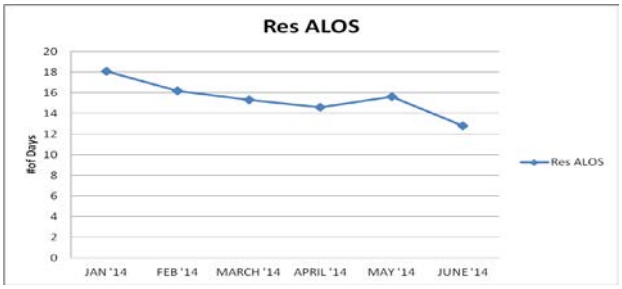
Acute IP

January 2014	February 2014	March 2014	April 2014	May 2014	June 2014
6.8	6.4	7.7	6.10	6.4	6.10



Residential

January 2014	February 2014	March 2014	April 2014	May 2014	June 2014
18.1	16.2	15.3	14.6	15.6	12.8



C. High-Complexity Member Initiative

Quarterly, the Louisiana Unit identifies the top 100 acute inpatient psychiatric bed day utilizers from the most recent running year. Of that population, members are ranked in descending order according to number of days utilized. The top 50 members become the treatment group for the High Complexity Rounds Initiative with the bottom 50 being considered a control group. Interventions are implemented during one quarter period and the total bed days for both groups are compared.

High Complexity rounds are conducted weekly during the intervention quarter and include several participants across the Louisiana Unit, including:

- UM/Medical Administrator
- Follow – Up Team
- Recovery and Resiliency Care Management (RCM)
- Clinical Management

Cases are prioritized according to acute inpatient admission status and reviewed by the team for history of inpatient presentation, primary symptomotology, diagnostic category, medical issues, outpatient treatment engagement, and SPA eligibility. Primary team interventions are inclusive of the following:

- Linking members to Independent Assessors for the purpose of establishing 1915(i) SPA eligibility
- Assigning members to RCM care management
- Linking members to a community-based service provider
- Coordinating care with community-based service providers
- Referring members with medical comorbidities to Bayou Health plans
- Referring members to physician advisors
- Teaming with after hours (AH) Iowa team actively manage admissions for the group as appropriate

The results of the interventions showed improved outcomes in the treatment group compared to the control group. The chart details the results for 2014.

Quarter	Group	Pre-Intervention Bed Day Utilization	Post-Intervention Bed Day Utilization	Change
Q1 2014	Tx Group	1549	481	69% reduction
	Control Group	299	236	21% reduction
Q2 2014	Tx Group	1152	459	60% reduction
	Control Group	314	448	43% increase
Q3 2014	Tx Group	1252	614	51% reduction
	Control Group	282	297	5% increase
Q4 2014	Tx Group	1228	471	62% reduction
	Control Group	308	368	19% increase

D. ACT Scorecard

Magellan has established benchmarks for performance in Louisiana to meet national standards for pay for performance and for system transformation. The Louisiana Unit created a scorecard for Assertive Community Treatment providers with a set of performance measures balancing services, fidelity, and outcomes, with the ACT scorecard already tied to a pay-for-performance model. The ACT Scorecard has measures of service (average encounters per member and members with more than six services), fidelity (DACTS), and outcomes (inpatient mental health admissions and rate and

emergency room visits for substance use or mental health). Thresholds for "green" and "yellow" for each measure were created by an analysis of historical provider data, utilization data from other Magellan public sector sites that also offer this service, and Medicaid national averages. A total score is calculated for a biannual adjustment in the rate for pay for performance. Quarterly scorecards are disseminated as well to assist providers in tracking interim progress.

The initial rate adjustment scorecard represented data from June 1 through August 31, 2014 and was disseminated to providers in October. The first biannual adjustment scorecard was disseminated in April and represented data from December 1 through February 28, 2015. The scorecard has proven to be an effective quality management technique that has lead to improved outcomes for the LBHP's most vulnerable adult members. As a result of the scorecard, there was a 15.7% decrease in readmissions to the inpatient level of care, with readmissions declining from a rate of 30.77% to 25.95%. Improvements could also be seen in the admissions per hundred. This metric declined from 19.59 admissions per hundred to 17.10. There was a 10.52% decrease in the average length of stay (ALOS), with days declining from 6.75 to 6.04. Of the twelve teams included in the scorecard intervention, eight showed decreases in readmissions and admissions per hundred, with one provider going from a 30% readmission rate in the first scorecard to a 0% readmission rate in the second scorecard. The picture below provides an example of the scorecard model.

ACT Scorecard for Q4 2014

Average Number of Encounters Per Member By Agency

Less than 6 Encounter	6-13 Encounters	14 or more Encounters			
	Previous	Q4 2014	Progress		
Provider 1	6.12	5.37	-0.75		
Provider 2	4.55	3.95	-0.60		
Provider 3	4.25	4.60	0.35		
Provider 4	8.11	9.20	1.09		
Provider 5	6.23	8.22	1.99		
Provider 6	7.87	9.73	1.86		
Provider 7	5.98	8.87	2.89		
Provider 8	8.58	9.35	0.77		
Provider 9	7.03	7.94	0.91		
Provider 10	4.98	4.91	-0.07		
Provider 11	6.19	5.72	-0.47		
Provider 12	6.35	6.28	-0.07		

Percentage of Members Having 6 or More Services

Less than 75%	75% - 99%	90% or Higher			
	Previous	Q4 2014	Progress		
Provider 1	48.8%	43.4%	-5.4%		
Provider 2	34.1%	23.5%	-10.6%		
Provider 3	29.2%	32.2%	3.0%		
Provider 4	73.9%	87.0%	13.0%		
Provider 5	63.0%	77.7%	14.7%		
Provider 6	69.3%	83.1%	13.8%		
Provider 7	62.3%	91.5%	29.2%		
Provider 8	74.5%	78.9%	4.4%		
Provider 9	72.6%	86.1%	13.6%		
Provider 10	59.0%	50.0%	-9.0%		
Provider 11	73.2%	58.5%	-14.7%		
Provider 12	62.1%	64.3%	2.2%		

IP Psych Hosp. Admits per 100 ACT Recipients

Greater than 16 Adm	16 - 5 Admits	Less than 5 Admits			
	Previous	Q4 2014	Progress		
Provider 1	11.70	7.60	-4.10		
Provider 2	4.17	1.69	-2.48		
Provider 3	6.45	2.78	-3.67		
Provider 4	12.61	6.19	-6.42		
Provider 5	9.86	7.72	-2.14		
Provider 6	7.69	8.05	0.36		
Provider 7	6.77	2.19	-4.58		
Provider 8	7.25	6.58	-0.67		
Provider 9	5.43	5.90	0.47		
Provider 10	5.83	6.47	0.64		
Provider 11	4.26	3.70	-0.56		
Provider 12	6.67	6.41	-0.26		

IP Psych Hosp Readmit Rate

Greater than 15%	15% - 5%	Less than 5%			
	Previous	Q4 2014	Progress		
Provider 1	40.0%	46.2%	6.2%		
Provider 2	33.3%	25.0%	-8.3%		
Provider 3	0.0%	33.3%	33.3%		
Provider 4	35.7%	15.4%	-20.3%		
Provider 5	37.9%	22.7%	-15.2%		
Provider 6	29.2%	14.3%	-14.9%		
Provider 7	23.1%	0.0%	-23.1%		
Provider 8	40.0%	34.5%	-5.5%		
Provider 9	35.7%	23.5%	-12.2%		
Provider 10	50.0%	38.5%	-11.5%		
Provider 11	22.2%	25.0%	2.8%		
Provider 12	10.0%	10.0%	0.0%		

VII. Recovery and Resiliency Care Management

At Magellan, we recognize there are a group of members who require intensive care management to support their recovery/resiliency efforts, to assist them in remaining in a community setting, and removing barriers to improved outcomes. These members are referred to our Recovery and Resiliency Care Management (RCM) program that provides focused and frequent care manager involvement for members who frequently use crisis services, have recurring readmissions to 24-hour levels of care, or have complex needs, including priority populations such as individuals with co-morbid HIV or pregnant women with substance use disorders. RCM Care Managers also assist with ensuring coordination between a member's behavioral and physical health providers. RCM also includes the use of Peer Recovery Navigators who work closely with members to educate them, enhance the use of recovery and resiliency principles, instill hope, provide support and direction, and assist the member in meeting treatment goals. They meet with the members at hospitals, assist them in provider offices, and become an active part of the member's recovery process.

Criteria for enrollment in the RCM program include meeting at least one of the following:

- Children/youth 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 ages 12 and under who are hospitalized.
- Pregnant women who use substances.
- Members ages 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 Governing Entities (LGEs), or other providers as needing Intensive Case Management.

In 2014, the Louisiana Unit RCM Program consisted of 9 FTE Care Managers and 1 FTE Care Worker. In the third contract year, 1,069 members were referred to RCM, 768 who chose to enroll in RCM. This represented an improved enrollment rate of 71%, which was 17 percentage points higher than contract year two's enrollment rate of 54%.

Some of the activities completed by RCM during contract year three include:

- Four (4) RCM Care Managers were assigned to work with the five Bayou Health plans to ensure appropriate coordination of care for physical and behavioral health need.
- The RCM Care Managers actively participate in the state's Birth Outcome Initiative program by connecting substance using expectant mothers to the appropriate services.
- RCM Care Managers complete crisis safety plans for all members enrolled in RCM and attach the plan to each member's file through the Magellan system.
- RCM provides education to emergency departments and providers about the existence and role of the RCM program.
- RCM Care Managers, in partnership with the other clinical teams and peer specialists, participated in the High Complexity Member Initiative detailed under the Care Management Initiatives.

The CHI and CHI-C tools are utilized by the RCM team to measure outcomes and members' experience of improvement. The below charts represent the percent of members indicating improvement in 2014.

CHI (Adults)	
Measures	**Percent of Members with Improvement**
Emotional Health	78%
Physical Health	44%
Behavioral Symptoms	57%
Strengths	68%
Provider Relationship	62%
Confidence in Treatment	46%
General Health	24%

CHI-C (Children)	
Measures	**Percent of Members with Improvement**
Emotional Health	78%
Physical Health	44%
Strengths	68%
Behavioral Symptoms	57%
General Health	53%

VIII. Evaluation of Over/Under Utilization of Services

One of the pillars of Magellan is to ensure members receive services that are individualized, effective, provided in the least restrictive setting and medically necessary. 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 Utilization Management Committee (UMC) monitors quality indicators to identify potential over and under-utilization of services. When an aberrant pattern or trend is identified, the UMC conducts a root cause analysis and recommends interventions to the QIC. This information allows the QIC to quickly identify where to focus improvement efforts.

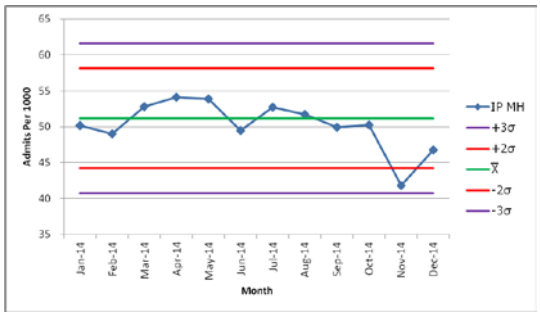
An overview of utilization management metrics that are evaluated by the UMC are provided in this section. They include:

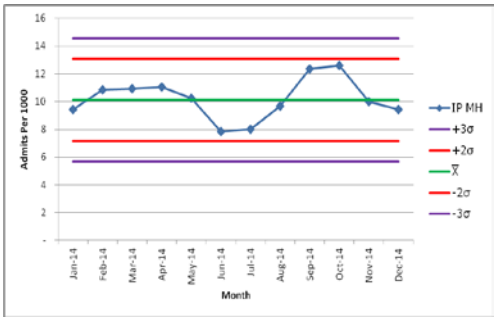
- Inpatient Hospitalization (IP) Mental Health (MH) Admissions per Thousand
- IP MH Average Length of Stay (ALOS)
- Residential Substance Use (SU) Days Per Thousand
- Residential SU ALOS
- Community Psychiatric Supportive Treatment (CPST) Average Number of Units (ANOU) and Members Served
- Psychosocial Rehabilitative Services (PSR) ANOU and Members Served
- Substance Use IOP and Members Served
- Other Outpatient ANOU and Members Served

The UMC utilizes control charts to evaluate utilization trends based on standard deviations from the mean to identify statistical over or under utilization detected. When evaluating the metrics, it is important to consider that trends become more stable as the data mature. Opportunities for improvement are indicated when over/under utilization or utilization above or below two standard deviations from the mean, are detected over a period of time. Control charts use data from March 1, 2012 to December 31, 2014. Graphs below represent data from calendar year 2014.

IP MH Admissions per Thousand

Adult **Child**

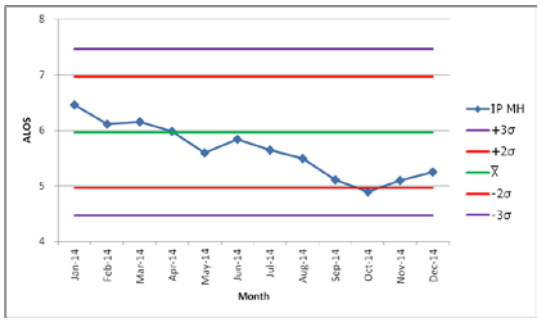




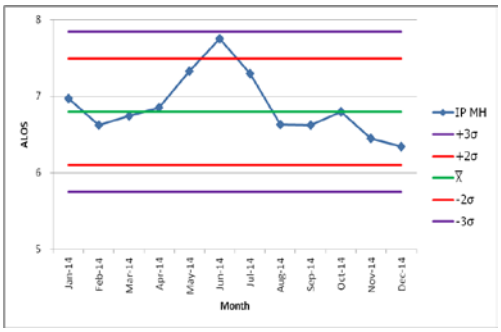
Both the adult and child inpatient mental health admissions per thousand metrics show an overall upward trend in 2014. The mean number of inpatient admissions per thousand is 51.2 for adults and 10.1 for children. The mean was slightly higher than the mean for contract year two which was 47.8 for adults and 8.32 for children. In 2014, adult data remained steady around the mean for most of the year, with a decline below one standard deviation in November 2014. Children admissions showed variability around the mean but remained within one standard deviation from the mean.

IP MH ALOS

Adult



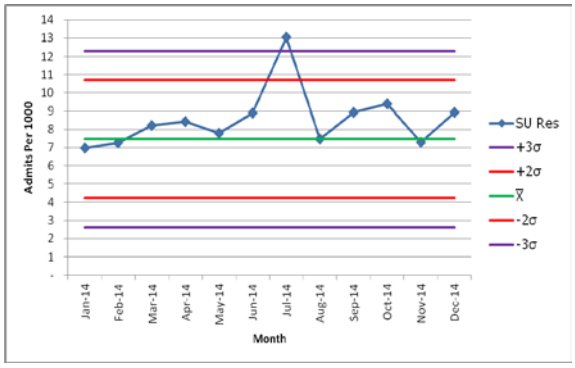
Child



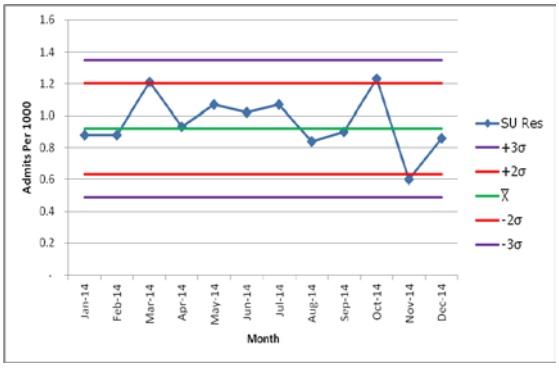
Both the adult and child inpatient mental health ALOS metrics showed an overall downward trend. The mean ALOS for IP MH for adults was 6.0 days, which was lower than the mean of 7.4 days ALOS for contract year two. ALOS for adults trended below the mean for most of the year. This can be attributed to 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 was 6.8 days, which also represents a decline compared to the mean of 8.2 days in contract year two. Children ALOS showed variability around the mean with a peak in May through July, with June 2014 showing admissions greater than one standard deviation from the mean. This peak was consistent to what was seen in previous years and most likely attributed to factors related to seasonality. ALOS did stabilize closer to the mean in the later six months of 2014.

SU Residential Admissions per Thousand

Adult



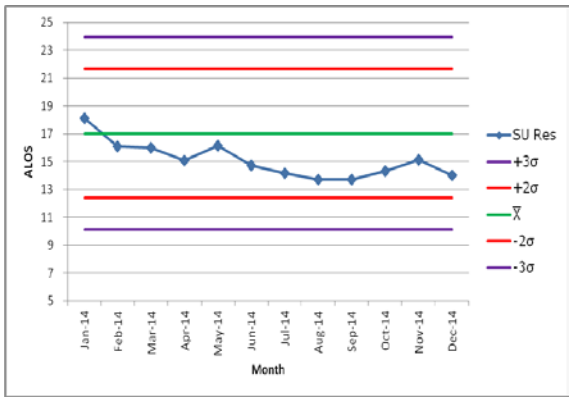
Child

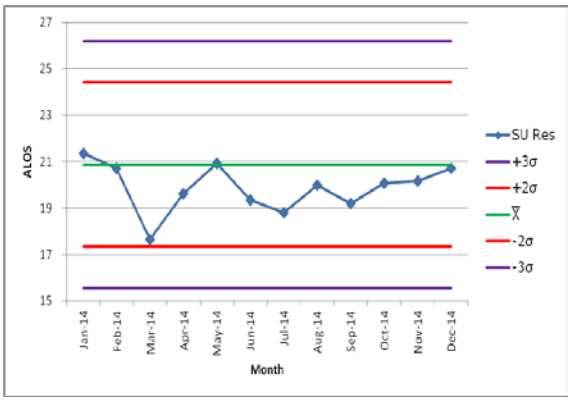


Both the adult and child substance use residential admissions per thousand metrics show an overall upward trend in 2014. In 2014, the mean number of admissions per thousand for Adult Substance Use (SU) Residential was 3.4, slightly higher than contract year two mean of 2.75. The mean for Child SU residential was 0.92, which was higher than the mean of 0.03 in contract year two. Because of the low numbers represented in these metrics, small shifts can appear to be significant. Both metrics showed some periods above one standard deviation from the mean; however, most data were within one standard deviation from the mean.

SU Residential ALOS

Adult **Child**





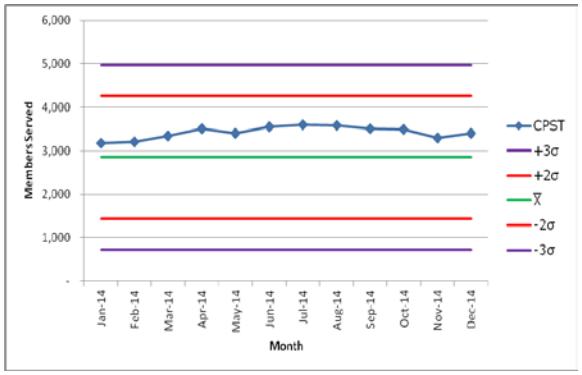
The mean ALOS for adult residential substance use was 17.0 days, slightly lower than the contract year two mean of 17.49 days. The child ALOS was 20.9 days, which represented a decline of the contract year two mean of 21.28 days. The data is trended below the mean for both populations, but did not show periods below one standard deviation of the mean. Magellan Care Managers continue to actively work with providers to promote individualized treatment models rather than traditional programmatic model (e.g., 28 days) to individualized treatment models.

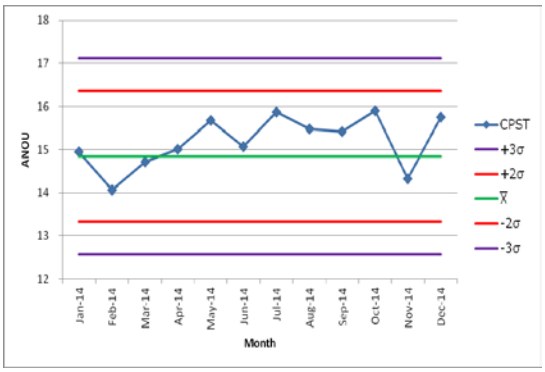
Adult Outpatient Average Number of Units (ANOU) and Members Served

Graphs for adult CPST, PSR, ACT, Substance Use IOP and other outpatient services are provided below. Members served data for all metrics are trending above the mean, which is consistent with the goals of the UM program. There was a 43.8% increase in members served in Substance Use IOP. ANOU show an upward trend for all metrics except other outpatient services. Increased utilization of Home and Community Based Services (HCBS) is attributed to the implementation of the Independent Assessment/Community Based Care Management program. The goal of the program is to increase number of members eligible for the 1915(i) State Plan Amendment, which funds HCBS services for members that meet financial and clinical criteria. Increased utilization of SU IOP can be attributed to care management initiatives to decrease institutionalization and increase community tenure for members dealing with substance use problems. The decrease in the ANOU of the other outpatient services category is believed to be attributed to increases in the HCBS.

Adult CPST

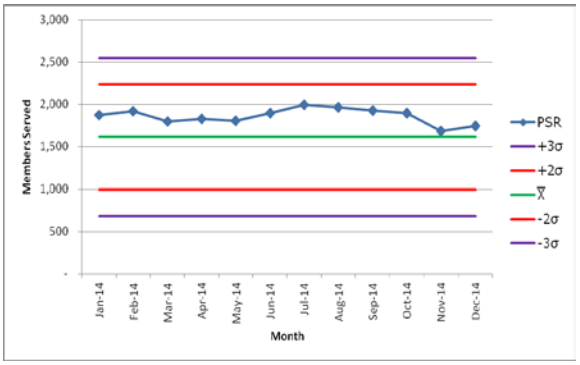
Member Served **ANOU**





Adult PSR

Member Served



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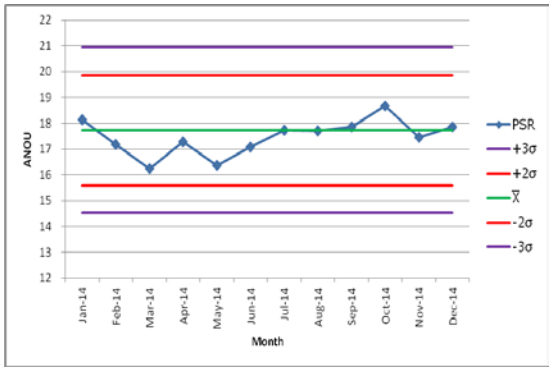
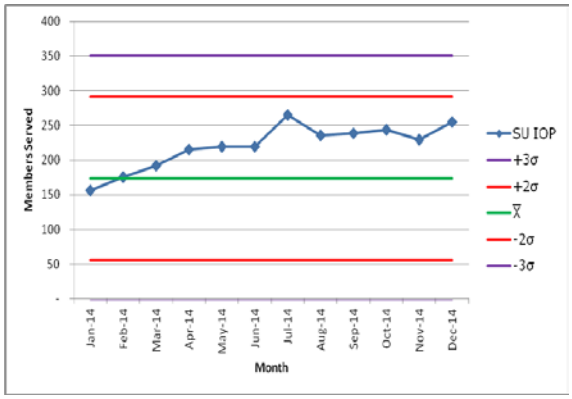


Adult Substance Use IOP

Member Served



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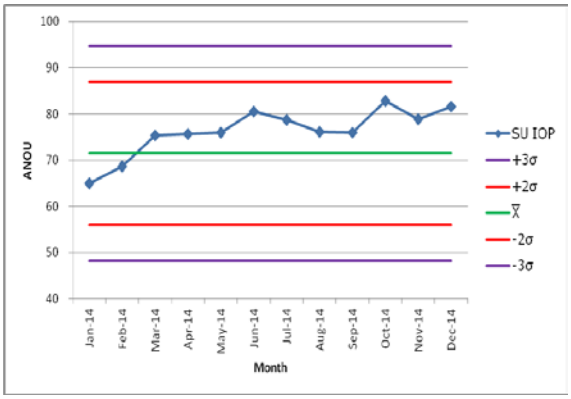
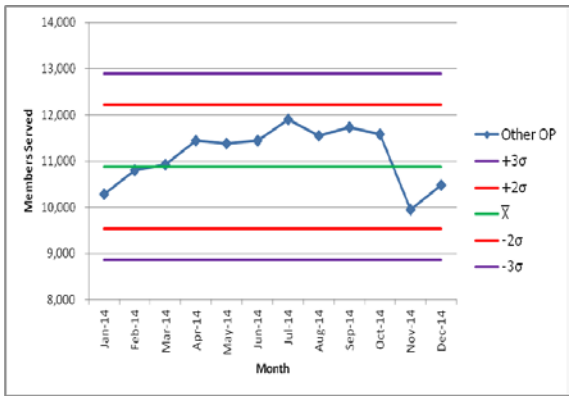
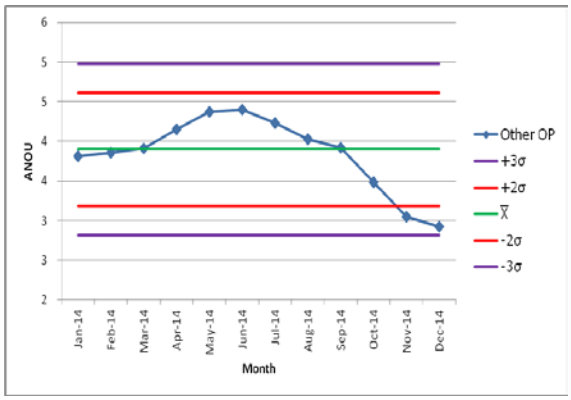


Other Outpatient Services

Member Served

ANOU



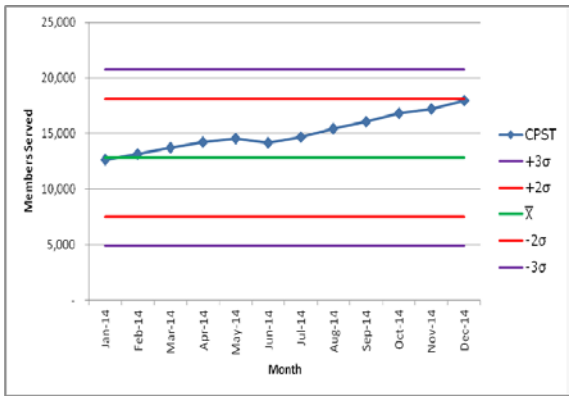


Child Outpatient Average Number of Units (ANOU) and Members Served

Graphs for child CPST, PSR, Substance Use IOP and other outpatient services are provided below. Members served data for all metrics are trending above the mean with most trending positively. There was a significant increase in child members served by Home and Community Based services. Utilization for CPST increased 34.6% and PSR increased 40.7% from January 2014 to December 2014. This indicates that more members are accessing services than in previous contract years. ANOU also showed an upward trend for all metrics.

Child CPST

Member Served



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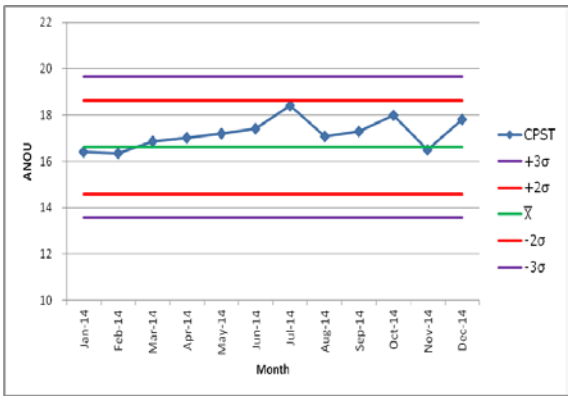
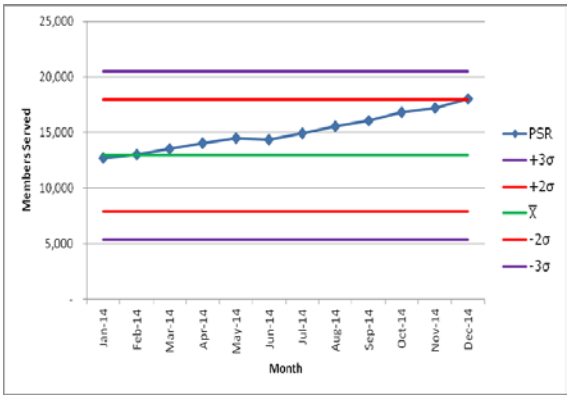


Child PSR

Member Served



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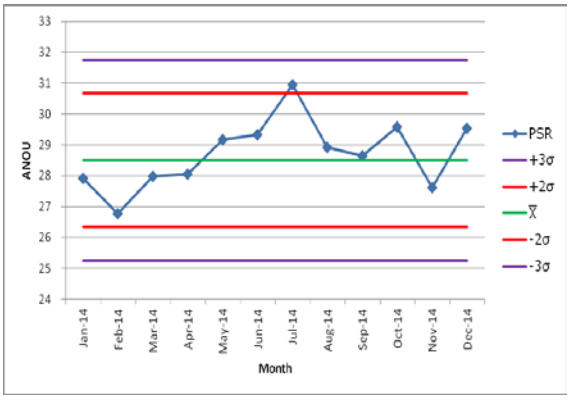
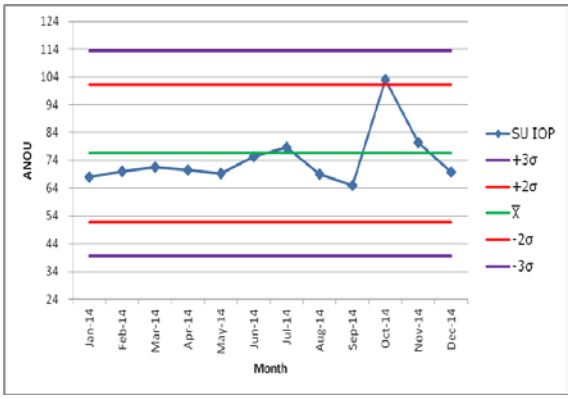


Child Substance Use IOP

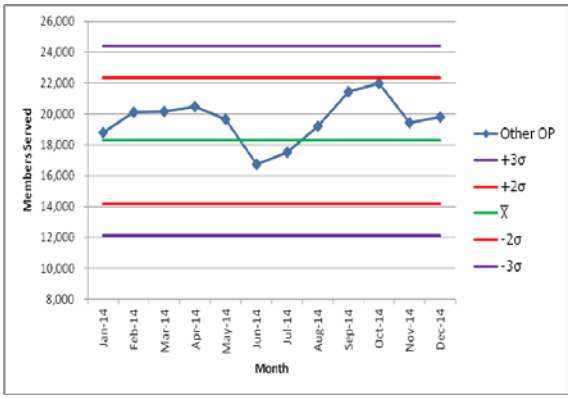
Member Served

ANOU



Other Outpatient Services

Member Served



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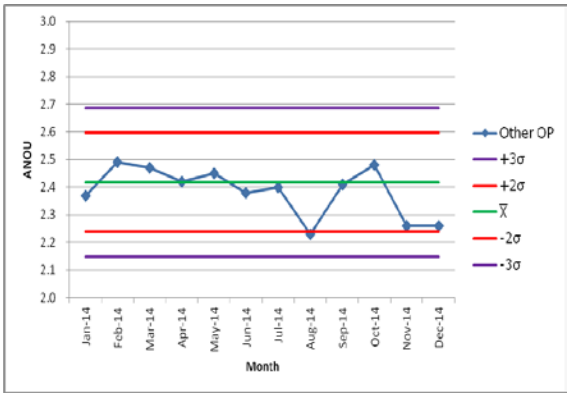
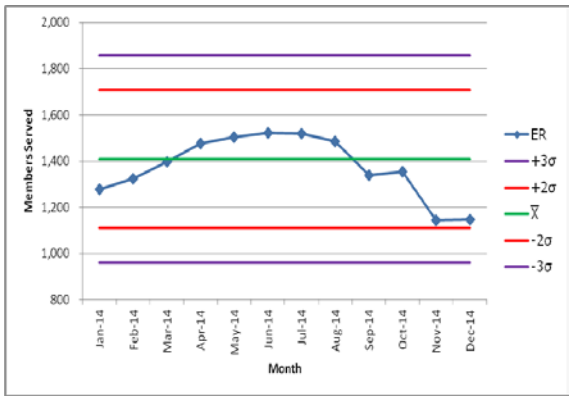


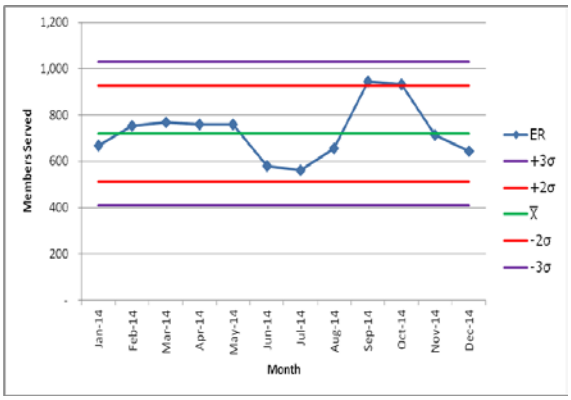
Emergency Room Utilization

Emergency room utilization appears to be variable for both the adult and child populations. The adult utilization remained within one standard deviation for calendar year 2014 with 7 months at or below the mean, and there is a downward trend in the later half of the year. Magellan implemented a pay for performance model (PFP) for ACT providers in May of 2014. As part of this model, Magellan provided scorecards that highlighted key quality indicators, including ER utilization. ACT providers service the highest acuity adult members in the system, and these members are often frequent utilizers of ERs. The PFP model incentivizes providers to develop interventions to decrease ER utilization and promotes improved outcomes. Child data showed utilization above one standard deviation in September and October; however most months showed utilization at or below the mean.

Adult



Child



IX. Screening Program Activities

The Louisiana Unit QI program develops and demonstrates ongoing screening programs to identify members that would benefit from behavioral health services. Magellan utilizes the Child and Adolescent Needs and Strengths Assessment (CANS) Comprehensive screening tool 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 an expanded array of home and community-based services not available to the general Medicaid population. In the third contract year, Magellan implemented the Independent Assessment/Community-Base Care Management approach to increase member access to assessors that conduct screenings for adults. Please refer to **Section XVII Behavioral Continuum (System Transformation)** for more details.

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 Unit 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 Unit 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. The Louisiana Unit care

managers, 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 Unit 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 Unit. 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
2014 Q1	70	0
2014 Q2	220	2
2014 Q3	370	109
2014-15 Q4	117	14
Totals	777	125

Magellan uses data from these multiple sources to promote improvement in integration between the medical and behavioral providers. First, our quality management team reviews for provider collaboration as part of their 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 expected to provide the PCP with information about the Member's ongoing needs, especially where a Member is hospitalized or requires complex services. Second, we use our grievance process as a means of identifying issues related to communication with PCPs.

When we receive an issue or concern regarding lack of coordination between the PCP and BH provider, our quality management or provider network staff reach out to the provider to address the issue. Third, our Care Managers review and ensure that care coordination exists as part of their care management functions. If a deficiency is identified, the Care Manager notifies the provider and, as needed, works with the provider to facilitate communication with the PCP. Finally, our care management system includes triggers that prompt the Care Managers to review the Member's medical records and plan of care to ensure coordination of care with the PCP, as needed. We contact Bayou Health Care Mangers to refer Members with medical needs but without an identified PCP. We will then collaborate with the Bayou Health plan to ensure a coordinated effort between the providers and the two entities to meet the Member's needs.

XI. Coordination of Care Activities

The goal of the LBHP care management program is to support members in achieving their optimal level of health and wellness, and improve coordination of care. Coordination of care for members across multiple levels of care, treatment episodes and transition periods has been a priority of the Louisiana Unit. The Louisiana Unit has focused on key activities that include:

- Enhanced involvement of follow-up specialists with members who are receiving treatment in inpatient settings;
- Implementation of bridge appointments;
- Implementation of statewide Independent Assessment Community-Based Care Management program to improve coordination of care for the adult SMPI population; and

- Implementation of a standardized (waiver-compliant) plan of care for children enrolled in CSoC and adults with 1915(i) SPA eligibility.

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 Louisiana Unit 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 to 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:

- Confirming demographic information with the patient and their family. Obtaining a current address and working phone number.
- Reviewing Discharge Plan and answer any questions.
- Discussing the importance of follow-up and how engagement in aftercare can reduce the chance of readmission.
- Discussing the importance of taking medication as prescribed. Giving suggestions that can assist with remembering medication such as a medication organizer, alarm, connecting with daily routine, etc.
- Discussing possible barriers for keeping the appointments so that Magellan staff can assist 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 were monitored via the Transitional PIP. Please see **Section V Quality Improvement Activities and Performance Improvement Projects** for details on outcomes. Another high utilization inpatient hospital will implement program in contract year four.

Another mechanism to coordinate care for children 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's 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.

In contract year three, Magellan also fully implemented a statewide Independent Assessor/Community Based Care Manager (IA/CBCM) program for adults with SMI. IA/CBCMs are conflict of interest free practitioners that collaborated with newly eligible for 1915(i) member and treating providers to construct a plan of care to meet the member's needs. This program is described fully in **Section XVII Behavioral Continuum (System Transformation).**

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 develops 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 coordinate with LaHIE provided LaHIE's readiness and availability.

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 *Outcomes 360* 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 Unit *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 Unit uses the CHI/CHI-C assessment as part of the RCM program to evaluate outcomes. It is also available for limited use by providers. From January 1, 2013 to December 31, 2014, there were 724 CHI assessments administered to members. Of these members, there were 215 second assessments and 107 third assessments conducted. The results indicated symptom reduction on both emotional and physical health scales. On the emotional scale, 57% of members reported improvement between administrations, with 42% showing statistically significant improvement. Fifty-three percent of members reported improvement on the physical health scale, with 34% showing statistically significant improvement. During the same time parameter, there were 1,721 CHI-C assessments administered to youths. Five hundred thirty seven youth received a second assessment and 318 youths received a third

assessment. The results indicated symptom reduction on both psychosocial and physical health scales. On the psychosocial scale, 54% showed any improvement with 41% showing statistically significant improvement. Thirty-eight percent of members also showed any improvement on the physical health scale with 22% showing statistically significant improvement.

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.

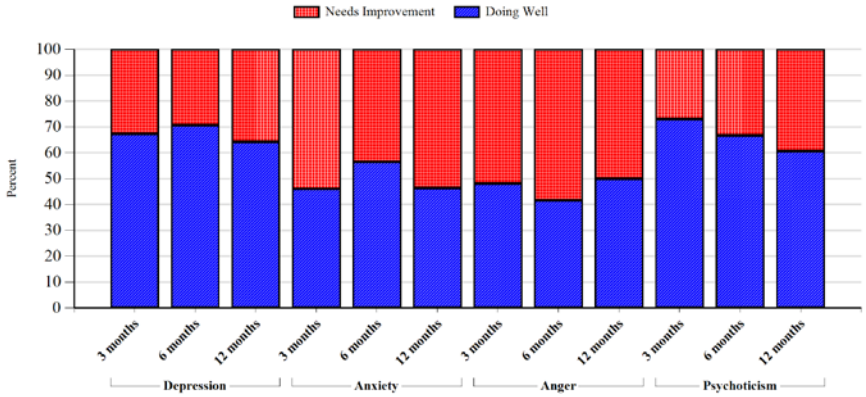
Data were collected using the Louisiana TOMS Aggregate Outcomes Summary Report Card located at https://outcomes.telesage.com/Outcomes/projects/Louisiana/ReportCardState.aspx. The evaluation looks at data from the fourth quarter (Q4) of the calendar year (October-December) 2014. The data is divided into 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). According to the TeleSage Report Card Information, Doing Well is defined as the percent of clients who improved or started out with low severity and remained low. It is indicated by blue diagonals in the graphs below and calculated by dividing the number of clients doing well by the total number of clients with available data. Needs Improvement is defined as the percent of clients who worsened or started out with moderate/high severity and remained moderate/high. It is indicated by red crosshatch in the graphs below and calculated by dividing the number of clients who need improvement by the total number of clients with available data.

New Clients

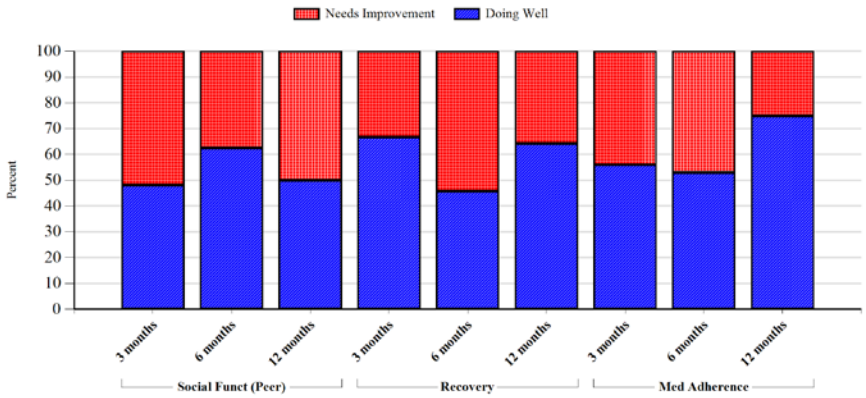
New clients are expected to have the TOMS administered within the first 30-days of admission and every three months of the first year. On average, 48 new clients responded to questions on the TOMS during the 3-month administration, 22 for the 6-month administration, and 28 for the 12-month

administration in 2014. This excludes the respondents for the metrics medication adherence and employment status, which showed lower over-all number of respondents. The symptom anger showed slight increase in the percent doing well from the 3 to 12-month administrations, psychoticism and depression showed a decline in percent doing well, and anxiety remained statistically the same. The following functional metrics showed at least 90 percent of the respondents doing well at all administrations: binge drinking, arrests, and homelessness. Improvements were noted for social functioning, medication adherence, employment status and independent living between the 3 and 12-month. Declines in the percent doing well were seen in recovery, binge drinking, drug use, and homelessness.

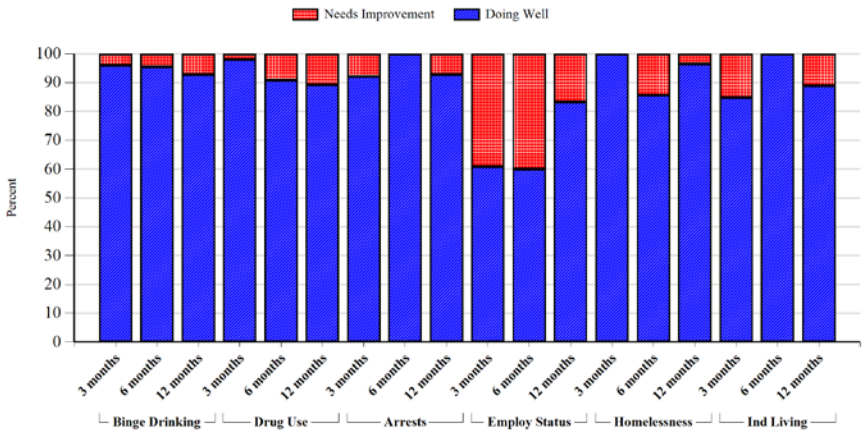
New Clients: Symptoms



New Clients: Functioning



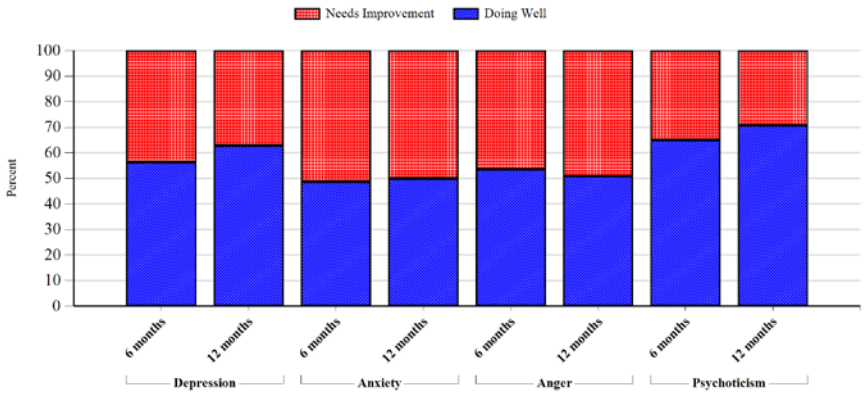
New Clients: Functioning



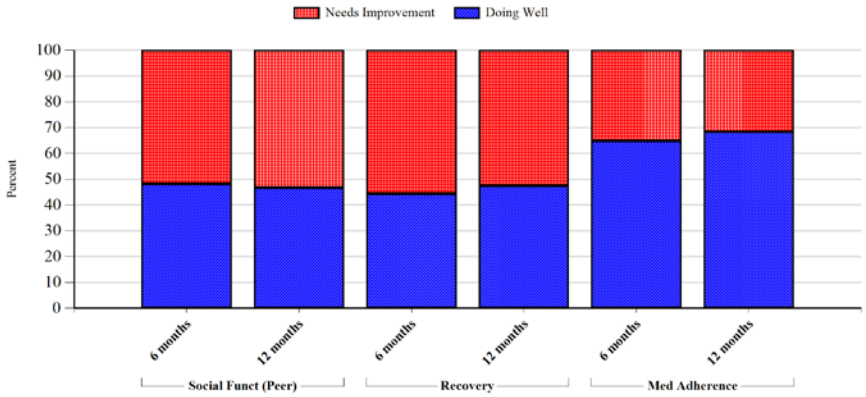
Existing Clients

According to OBH, existing clients are expected to have the TOMS administered every six months. On average, 184 existing clients responded to questions on the TOMS at the 6-month administration and 116 at the 12-month administration during calendar year quarter four (October-December). This excludes the respondents for metric on employment status, which only had 43 respondents at the 6-month administration and 23 at the 12-month administration. Three of the four symptoms metrics (depression, anxiety, and anger) showed improved outcomes from the 6 to 12-month administrations, with psychoticism showing a slight decline in percent doing well. The following functional metrics showed at least 90 percent of the respondents doing well at both the 6 and 12-month administrations: binge drinking, drug use, arrests, and homelessness. Improvements were noted for recovery, medication adherence, and employment status between the 6 and 12-month. Declines in the percent doing well were seen in social functioning, binge drinking, drug use, and homelessness.

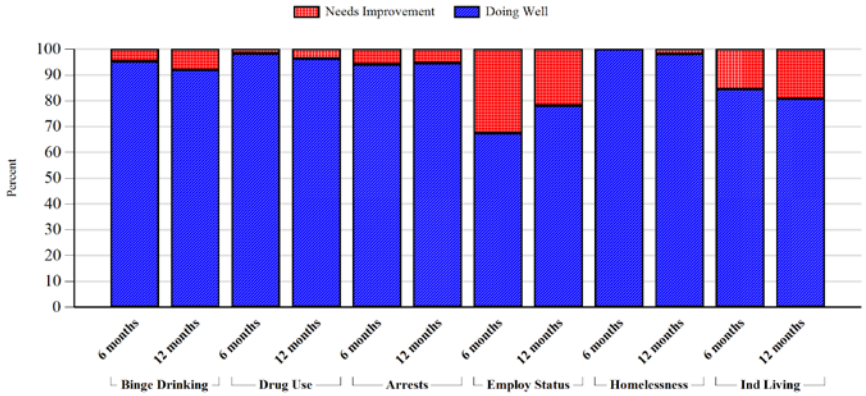
Existing Clients: Symptoms



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:

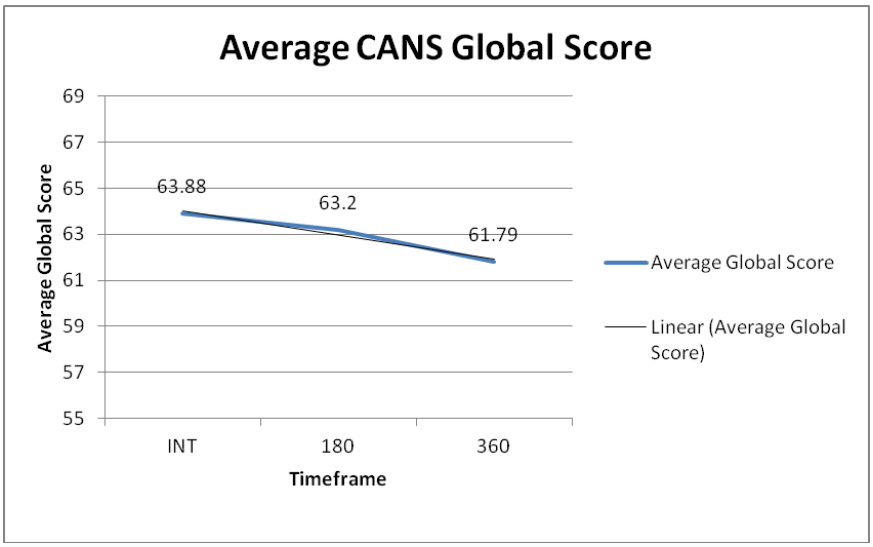
- Life Domain Functioning
- Youth Strengths

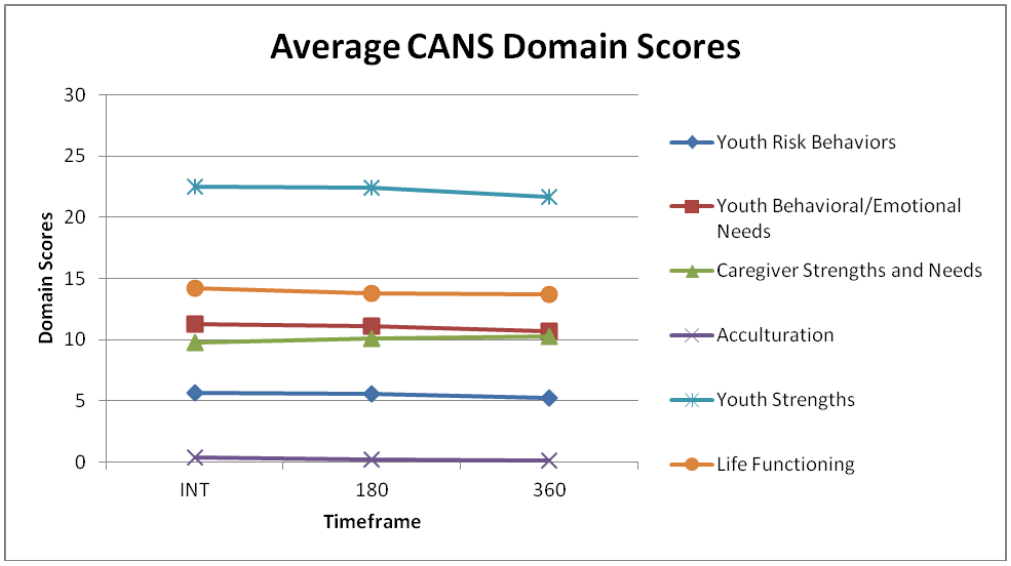
- Acculturation
- Caregiver Needs and Strengths
- Youth Behavior/Emotional Needs
- Youth Risk Behaviors
- Includes additional modules for school, developmental needs, substance use, trauma, violence, etc.

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. CANS Assessments are completed at the initial assessment and every 180 days thereafter. The CANS serves as both an eligibility and outcomes tool. Algorithms categorize members into Levels of Need to identify member acuity, with Inpatient being the highest and CSoC being the lowest for waiver eligibility. In January 2014, there was a scoring algorithm change implemented to more accurately capture inpatient eligibility for the waivers. Because of the change, Magellan shifted to the use of the CANS global score, or a total of all elements, to measure outcomes. Using the CANS global score for outcomes enhances the reporting capabilities to allow for more advanced data analytics to monitor outcomes.

Outcomes Data

A weighted sample by CSoC region enrollment of 125 members that were enrolled in CSoC is pulled each contract quarter. The sample includes all members enrolled in CSoC more than 360 days; hence, the sample size represents a higher acuity population. CANS data were pulled from the member case file for initial CANS, 180-day CANS, and 360-day CANS. The sample does not include discharge CANS. The below graphs depict contract year quarter four data. There were improvements noted.


Average CANS Global Score
69
67
65
63
61
59
57
55
Average Global Score
63.88
63.2
61.79
INT
180
360
Timeframe
Average Global Score
Linear (Average Global Score)


Average CANS Domain Scores
30
25
20
15
10
5
0
Domain Scores
INT
180
360
Timeframe
Youth Risk Behaviors
Youth Behavioral/Emotional Needs
Caregiver Strengths and Needs
Acculturation
Youth Strengths
Life Functioning

XIII. Patient Safety

Magellan in Louisiana has an ongoing process for monitoring patient safety through member grievances, accessibility measures, quality of care concerns and adverse incident reports. The ongoing monitoring of these measures individually and in aggregate allows the Louisiana Unit to identify trends, which may require adjustment to the network, unit 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 XIX 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:

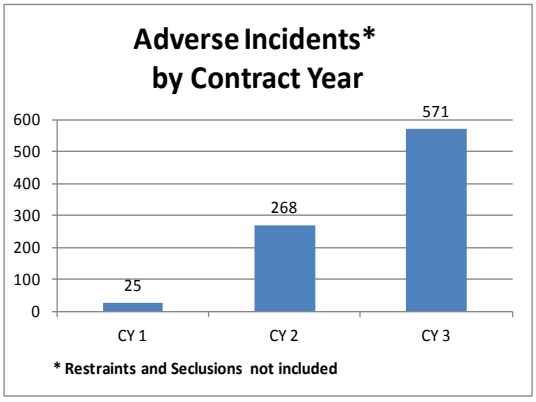
- Death
- Suicide Attempt
- Significant Medication Error
- Event Requiring Emergency Services (of the fire department or a law enforcement agency)
- Abuse (Physical Abuse, Psychological Abuse, Sexual Abuse, or Exploitation)
- Serious Injury or Illness
- Missing Person
- Seclusion or Restraint

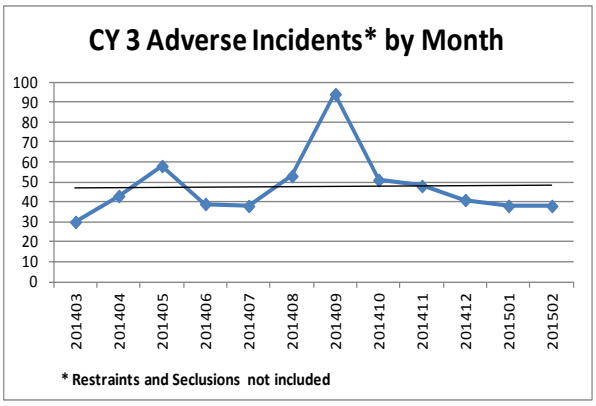
When an adverse incident is identified, whether by a phone call or reference from a member, provider, caregiver, etc., the Magellan representative completes a standard form and forwards it the QM department for entry into the database and investigation. If a member is reporting the concern, the member's 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 incidents.

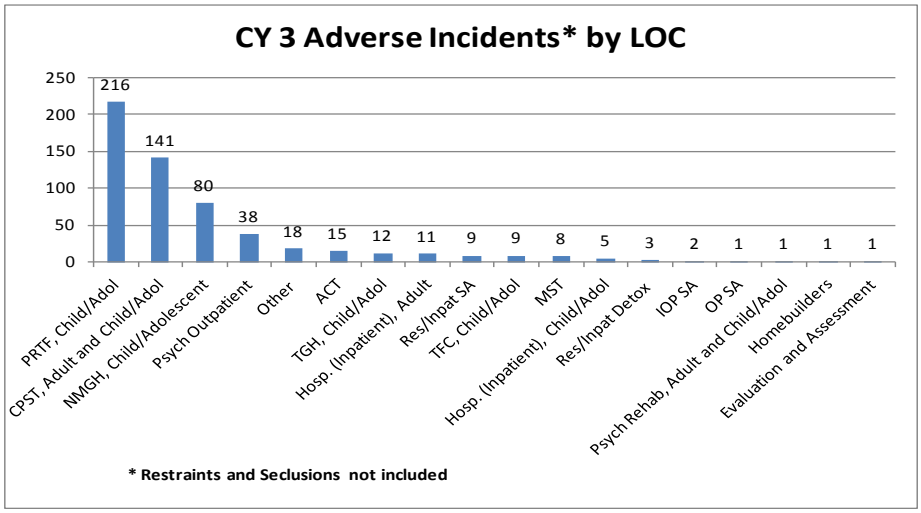
All incidents involving abuse are reported to the appropriate regulatory body and to the guardian when the involved member is a minor. The CMO or medical representative addresses any urgent clinical issues with the provider to ensure member safety. The QOC work group, a multidisciplinary team including 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 review 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.

All 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 three data is provided below.







In contract year one, Magellan received 25 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 Unit. 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 Unit received a total of 235 adverse incident reports in contract year two, which was a 770% increase in incident reporting. In contract year three, the Louisiana Unit received a total of 571 adverse incident reports which represents a 143% increase in incident reporting from contract year two. Magellan identified an opportunity for improvement that all levels of care were not reporting adverse incidents, especially at the inpatient level of care, as required. In contract year three, Magellan implemented a formal performance improvement project to improve reporting that can be referenced in **Section V Quality Improvement Activities and Performance Improvement Projects.** Interventions for this project focused on improving provider awareness of reporting protocols and increasing accountability through augmented monitoring.

Analysis of Incident Type

Analysis of suicide and homicide rates indicate the Louisiana Unit is trending below the national average According to the Centers for Disease Control and Prevention (CDC), the overall age-adjusted suicide rate in the United States was 12.6 per 100,000 in 2012. In calendar year 2014, the rate of suicide for the Medicaid eligible population for Louisiana was 0.69 per 100,000 and the rate for suicide for the members served was 5.94 per 100,000. The CDC indicated that the overall age-adjusted homicide rate in the United States was 5.2 per 100,000 in 2013. In calendar year 2014, the rate of homicide for the Medicaid eligible population for Louisiana was 0.48 per 100,000 and the rate for homicide for the members served was 4.12 per 100,000. These are both below the CDC overall age-adjusted rates for the United States. Magellan has not identified any aberrant patterns by provider; however, Magellan will enhance reporting in contract year four to include if a provider meets a threshold of more than 2 reports of death or suicide during a three month period. The report will include action steps and the status of the incidents.

Magellan identified a pattern involving elopements. Elopements were highest incident type reported in both contract year two and three. Elopements are generally reported at the PRTF and NMGH levels of care. Although each incident is reviewed at the individual level to ensure no patient safety issues exist, Magellan did implement increased monitoring requirements to address the volume of elopements reported. In contract year four, Magellan will enhance reporting to include details on any member that meets or exceeds a threshold of 3 or more elopements per month. Reporting will also include if the provider meets or exceeds total of five or more elopements per month and provider action plan to reduce the number of elopements.

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

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) is focused on improving the Member experience of care as related to quality. Magellan has a comprehensive process to track, review, and investigate QOC concerns. Magellan provides a standardized mechanism for external Members, providers, stakeholders, agencies, and the State as well as internal Magellan staff to report QOC concerns in order to ensure every voice is heard. This integrated workflow allows the QM program to place great emphasis on 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 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.

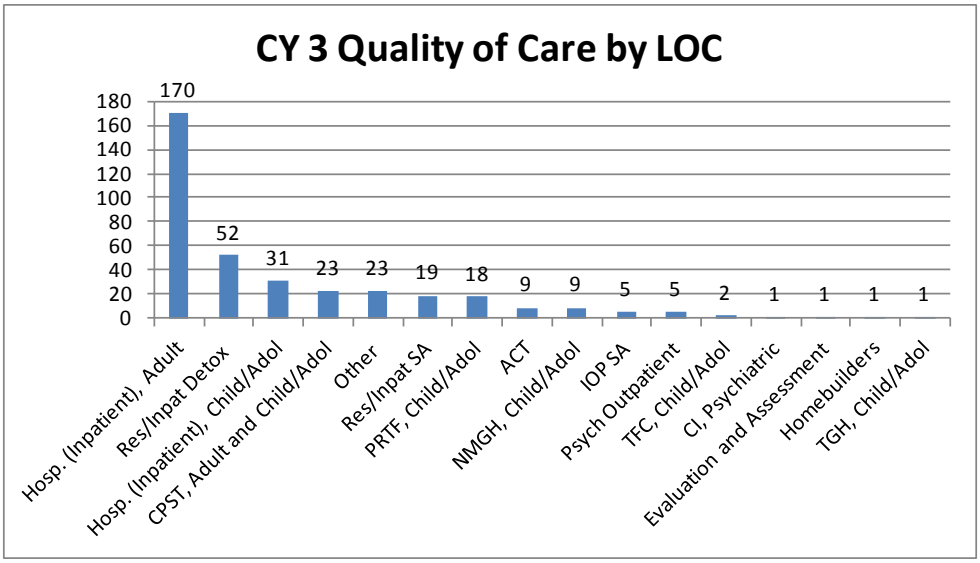
QOC reports are analyzed for patterns and trends, such as a disproportionate number of a type or category of concern or a high or increasing number of concerns related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the RNCC conducts a root 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 three by type and LOC.

Analysis

In contract year three, 370 QOC concerns were submitted. The largest categories of concerns reported were 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. The charts below provide details on the concern types and LOC associated with QOC Concerns.

Type	Number
Appropriateness of Care	155
Inadequate or Inappropriate Aftercare/Discharge Planning	70
Other Administrative (specify below)	32
Coordination of Care	28
Compliance with Utilization Management	20
Other Quality of Care (specify below)	13
Adequacy of Facilities	12
Timely submission of Evals, Tx Plans, Discharge Summaries	10
Complete Documentation	9
Accurate claims submission	5
Professional Behavior	5
Compliance with Quality Improvement	4
Access to Services	3
Compliance with Credentialing	2
Confidentiality	1
Failed to Notify MBH of Svc Delivery Issue/Stopped Services	1
Grand Total	**370**



XIV. Treatment Record Reviews and Clinical Practice Guidelines

Magellan has established a robust monitoring process focused on collaborating with providers to identify solutions to improve quality of service delivery and adherence to federal regulations. The Treatment Record Review (TRR) process is one of the key activities to collect data on the quality of its network providers. The TRR process is based on a robust yet adaptable corporate policy to ensure compliance with quality standards and federal and State guidelines. Magellan has developed web-based auditing tools to increase efficiency and accuracy of data analysis. Magellan was also able to customize this corporate procedure to collect data on federal and State performance to better inform the QM program. Aggregate TRR data is reported through the quality committee structure and currently shows that the overall provider network is functioning above the national Magellan minimum performance threshold of 80 percent.

Results

One hundred ninety-three providers (n=2000 charts) were reviewed for a TRR, Waiver and/or PIP. Follow up review from March 1, 2014 through February 28, 2015 through the use of the web tool. The overall network compliance rate for contract year three was 86.4%, which is 6.4 percentage points above the 80% minimum threshold. Fourteen of the eighteen TRR Core sections overall scores were above the 80% minimum threshold, with nine of those averaging from 91.9% to 100%. Four measures fell below the 80% minimum threshold, ranging from 24.6% to 73.5%. A measure for Adverse Incidents was added to the web tool late in the contract year and had an n=2 for the year, so is statistically insignificant. Four providers were referred to SIU based on information discerned in the process of quality audits during this time period.

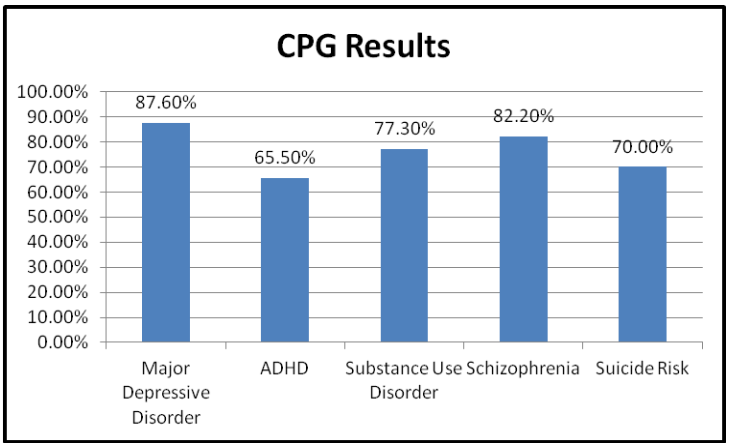
CORE Sections	Elements Meeting Compliance	Elements Items	Compliance Rate (%)
A - General	7,276	7,535	97%
B - Consumer Rights and Confidentiality	5,863	7,973	73.54%
C - Initial Evaluation	22,008.5	23,947	91.91%
D - Individualized Treatment Plan	7,645	9,408	81.26%
E - Ongoing Treatment	16,811	19,722	85.24%
F - Addendum for Special Populations	1,314.5	1,537	85.52%
H - Coordination of Care	2,130	3,652	58.32%
I - Medication Management	3201	3,808	84.06%
Addendum - Access to Care	585	599	98%
Addendum - Cultural	1,741.5	1,866	93.33%

Addendum - Service Delivery	1,779.5	1,843	96.55%
Addendum - Discharge	3,210.5	3,936	81.57%
Addendum - Medication Management	1,055.5	1,481	71.27%
Addendum – EBP: FFT	163.5	166	98%
Addendum - EBP: MST	519.5	534	97.28%
Addendum - EBP: Homebuilders	154.5	160	96.56%
Addendum - OBH/LGE Addendum	144	586	24.57%
Addendum – Restraints/Seclusion Totals	152	152	100%
Addendum - Adverse Incidents	0.5	2	25%

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. Guidelines, when changed, are updated on the website and providers are notified of any change through the online newsletter. Magellan's adopted guidelines are intended to augment, not replace, sound clinical judgment. The Clinical Practice Guidelines are available to all Magellan providers on the Magellan provider website. A list of the Clinical Practice Guidelines and a direct link to those guidelines is provided on the Clinical Practice Guidelines page of the Magellan of Louisiana website with the expressed requirement that all Magellan providers are responsible to be familiar with these guidelines. Both the Quality section of the Magellan of Louisiana web site and the Magellan's Provider Handbook includes a PDF version of the CPG Audit tools.

The Louisiana Unit monitors CPGs for Major Depressive Disorder, ADHD, Substance Use Disorder, Schizophrenia, and Suicide Risk as part of its TRR process. Data for contract year three indicates Major Depressive Disorder and Schizophrenia CPGs are above the 80% minimum compliance threshold, while CPGs for ADHD, Substance Use Disorder, and Suicide Risk were below the minimum performance threshold.



Performance Improvement Plans

Magellan has adopted procedures for Performance Improvement Plans (PIPs) to be implemented not just for providers with overall scores below established thresholds but also when a section or relevant element does not meet standard. Magellan also has policies in place to require all providers who do not meet 100 percent compliance standards for 1915(i) State Plan Amendment and 1915(c) and 1915(b3) Waiver performance measures to submit a PIP on how they intend to address deficiencies. PIPs are viewed by Magellan not as punitive in nature but rehabilitative and constructive. Magellan Clinical Reviewers provide education and resources to providers to ensure an understanding of opportunities for improvement. Magellan disseminates a detailed results letters following a review that identifies the provider's strengths, opportunities for improvement, and any required corrective action 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 actively offer and 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 review to monitor progress.
- Informal PIPs
    - TRRs with aggregate score between 79%-70%.
    - 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 this time period. The following chart represents provider specific data for March 2014 through February 2015.

Total Facilities Reviewed	Formal PIP	Informal PIP	Waiver CAP	Total PIPs/CAPs
193	16	130	20	166

Opportunities for Improvement

Magellan utilizes TRR data to collaborate with providers with the goal of improving the service provided to our Members. All data are analyzed for patterns and trends, such as a categories that fall below the threshold over a period of time. When an aberrant pattern or trend is identified, the QI department 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. Macro network opportunities for improvement and key drivers of non-compliance for contract year three include:

- **Member Rights & Confidentiality**
  - Signed psychiatric advance directives.
  - Signed informed consent for medications.
  - Releases for communication with PCP and other relevant providers.
- **Coordination of Care**
  - Documentation of request to member for PCP communication.
  - Record reflects continuity and coordination of care between behavioral health providers.
- **Addendum: Medication Management**
  - AIMS performed and documented if member is being treated with antipsychotics.
- **Addendum: OBH/LGE**
  - TOMS administered initially and at the designated intervals.
- **Clinical Practices Guidelines**

- ADHD
- Substance Use Disorders
- Suicide Risk

In contract year three, interventions were implemented to assist the overall provider network to better understanding documentation requirements as well as to provide education and resources to providers. A training outlining the purpose of documentation monitoring, the monitoring process, and specific quality requirements was presented during the March 2014 All Provider Call and was uploaded to the provider web page. 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 on the Quality page of the Magellan of Louisiana web site. Monthly reminders of these resources are given at each All Provider Call as well as at each individual audit. The following trainings, with downloadable PowerPoints, have been provided by QI on targeted areas exhibiting deficits during contract year three:

- Treatment Planning on August 2014 All Provider Call
- ADHD Clinical Practice Guidelines on September 2014 All Provider Call
- Crisis Plan Development on the December 2014 All Provider Call
- ASAM on the January 2015 All Provider Call
- Coordination of Care on the February 2015 All Provider Call

Other interventions implemented in contract year three to address systematic opportunities for improvement include:

- **Informed Consent for Medications**: The compliance rate for medication consents has been low and of concern to Magellan. Magellan Louisiana QI sought guidance on informed consents for treatment and medication from a forensic boarded Louisiana licensed psychiatrist. The result of this consultation is an expansion of the audit criteria to include the current guidance for MDs that consent is not adequately, or even advisedly, covered in a one time dated form, but ought to be expressed in documentation as a process. While Magellan Louisiana QI will continue to accept specific consent forms as meeting compliance, we will also include documentation in progress notes and be requesting providers' Policy and Procedure/Protocol on informed consent as well the provider's peer review process and protocol.
- **ADHD CPG:** Magellan conducted a training on the ADHD Clinical Practice Guidelines in the August 2014 Provider All-Call to improve provider understanding of practice guidelines. A breakdown of the specific items on the ADHD audit tool indicate that providers appear now to be utilizing multiple sources of information, such as scales or checklists from parents and

teachers, but many are not including a comprehensive assessment for comorbid psychiatric disorders and are not coordinating with the primary care physician to rule out medical causes for behavior. This deficit overlaps with the lower scores on TRR core for Coordination of Care. A second expanded presentation on Coordination of Care, including coordination with both primary care physicians and behavioral health providers, was presented on the All Provider Call in February 2015.

- **SUDS CPG:** An examination of the detail on the Substance Use Disorder CPG indicates that providers appear to be educating members well on substance use disorders and helping them to plan for sobriety. The primary area of deficit is neglect of conversations and referrals for abstinence-aiding medication. An ASAM Presentation was given on the January 2015 All Provider Call and these items were addressed.
- **Suicide Risk CPG:** An examination of the specific items on the Suicide Risk CPG indicate that providers are doing a good job of identifying members with high risk factors, but many are failing to assess for and develop a plan related to access to lethal means, assess and intervention for possible impact of substance use and psychosis, and involving the member's family/support system. Magellan conducted a Crisis Plan Development presentation on the December 2014 All Provider Call to address this items. In July 2014, a tip sheet entitled "Assessing and Managing the Suicidal Patient: Keeping the Patient Safe" was uploaded to the Quality section of the Magellan of Louisiana website. Announcements on the monthly All Provider calls continued to direct providers to this tip sheet for several months after it was posted.

Global educational efforts by Magellan through the All Provider calls and the Magellan of Louisiana website have not always produced the level of improvement sought on some of the specific measures on the Treatment Record Review. Therefore Magellan is creating specific and focused emails highlighting information on each of the more intractable compliance measures. These emails will be sent to targeted provider groups. An example in process at the time of this writing is an email to CPST/PSR providers in Louisiana highlighting the need for a 90 day review of the Plan of Care.

XV. Inter-rater Reliability

Magellan provides extensive ongoing training and consultation to Care Managers to ensure the appropriateness and quality of our clinical services. We use a multi-faceted approach to monitoring the accuracy, appropriateness, and timeliness of care management activities and provide training for any areas requiring improvement. The following are some of the processes we use to ensure inter-rater reliability when making medical necessity determinations:

- **Clinical Rounds/Case Conferences:** A stimulating educational forum for clinicians to enhance their expertise and skills in diagnostics, crisis management, service authorization criteria, and community resource knowledge. During the rounds/case conference (one-on-one or group), Care Managers have the opportunity to present challenging or problematic cases. At least one supervisor will be present, including a member of the medical team. The presentation is followed by a discussion of the clinical issues of the case, which often results in suggestions or recommendations for improvement, highlighting teaching points of the case, or suggesting other interventions or consultations that could have been attempted. Medical necessity and proper interpretation of criteria will be an integral part of the discussion.

- **Inter-rater Reliability Studies:** Magellan's clinical policy provides for annual measurement of the consistency of application of service authorization criteria by care management staff,

Physician Advisor Consultants, and Medical Directors. The measurement process conforms to customer, NCQA, URAC, and licensing requirements. The annual inter-rater reliability study establishes a process with all clinicians reviewing an identical set of vignettes to measure the national inter-rater reliability performance rate. Information gained from these inter-rater reliability reviews will be used for individual or departmental clinical training.

- **Training:** On a regular basis, Magellan offers clinical training sessions. For Magellan to meet its goal providing the right service at the right time for the right amount of time, the clinical staff receives ongoing education to ensure clinical best practices and processes are being followed. The training sessions address topics that are critical to the clinical staff's performance with regard to the accuracy and appropriateness of authorization determinations.

- **Call Monitoring:** Magellan uses the Qfiniti Enterprise suite, a comprehensive and integrated system that records calls and enables us to deploy proven, scalable quality monitoring and Care Manager evaluation programs. Through analysis capabilities, we can determine mentoring and coaching opportunities for Care Managers. Evaluation tools for care managers include questions on the following core performance areas: clinical content and documentation; utilization review; recovery and resiliency; timeliness of reviews, notification, and data entry; adverse determination, denial, and review notification; and motivational interviewing. Each month, clinical supervisors audit three calls for each Care Manager. Results from a Care Manager's audits are reviewed with the individual and the results from the full care management department are aggregated per team. This process provides information for direct supervision and prompt remediation when concerns are noted.

- **Documentation Audits:** These are incorporated into Qfiniti audit capabilities. Magellan's clinical supervisors complete at least three clinical documentation audits per Care Manager, per month, with a target of 90 percent compliance or better. The audits monitor compliance with policy, customer-specific requirements, and accreditation requirements. Care Managers receive copies of their monthly audits and are coached in areas of documentation noncompliance.

- **Ongoing Data Analyses and Reporting:** Magellan conducts numerous ongoing data analysis and reporting activities that will yield daily, weekly, monthly, and other results and formal reports. As one example, the Clinical Non-Authorization Overturn Rate is often included in Magellan's Quality Work Plan. It is an indicator that monitors the rate of clinical non-authorizations which are overturned during the appeal process. For each month in which this rate is greater than 20 percent, our Medical Director reviews the cases which were overturned to determine if there is a trend that can be further analyzed and applied to future service authorization criteria determinations. Building this process into routine oversight activities ensures that Magellan is

applying a CQI approach in their monitoring activities. The results can also be used for Care Manager training purposes.

In addition to supervisory trainings and participating in regular clinical trainings, all clinical staff receive ongoing training and updates on policies, procedures, and systems enhancements. This ongoing training is coordinated and facilitated by the local Clinical Trainer in collaboration with the Corporate Learning and Performance Department. All of these efforts provide a robust and comprehensive approach to ensure that medical necessity decisions are made using the most up to date clinical information.

XVI. Evidence-Based and Best Practice Initiatives

Our QM approach promotes a Member-centered, recovery and resiliency-oriented, evidence-based behavioral health care model consistent with Louisiana's goals. It focuses on driving and rewarding quality; measuring, assessing, and continually improving participant outcomes; and promoting the use of evidence-based practices. The Louisiana Unit 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.

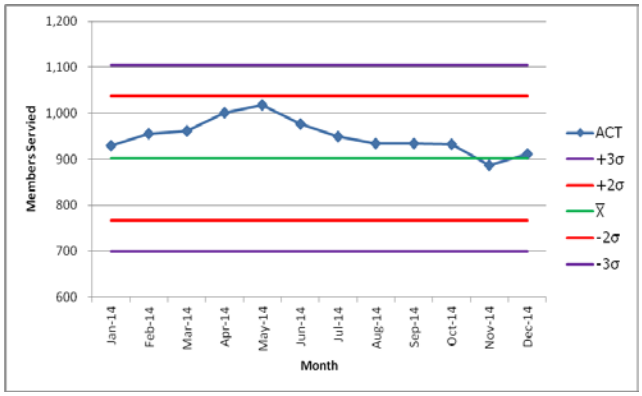
A. Assertive Community Treatment (ACT)

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.

There were sixteen contracted ACT teams that served 1451 unduplicated members in calendar year 2014. There was a mean of 902.1 members served. Utilization remained above the mean for most of the year.



ACT services were monitored by the QI department to insure minimum fidelity standards. 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. Fidelity monitoring is conducted by Magellan for teams with more than 50 members, of which fourteen teams qualify. During contract year three, fidelity onsite reviews were conducted for fourteen ACT teams and all teams scored good using the DACTS rating. This was an improvement from contract year two in which two teams fell in the fair category. Also, for the GOI rating, all teams scored in the Good Range. 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.

ACT Program Fidelity (DACTS) Score			
Team	CY2	CY3	Improvement (Raw Points)
CBS	116.00	118.00	2.00
FPS Metairie	116.00	121.00	5.00
FPS Slidell	N/A	121.00	N/A
NHS Alexandria	114.00	117.00	3.00
NHS BR	111.00	120.00	9.00
NHS Lafayette	119.00	126.00	7.00
NHS Lake Charles	114.00	123.00	9.00
NHS NOLA	121.50	129.00	7.50
NHS Shreveport	119.00	123.00	4.00
RHD New Orleans	117.00	119.50	2.50
RHD ACT	121.50	124.00	2.50
VOA Lafayette	107.00	121.00	14.00

As described **in Section VI Care Management Initiatives**, Magellan has established benchmarks for performance in Louisiana to meet national standards for pay for performance and for system transformation. The Louisiana Unit created two scorecards for evidence based practices with a set of performance measures balancing services, fidelity, and outcomes, with the ACT scorecard already tied to a pay-for-performance model. The ACT Scorecard has measures of service (average encounters per member and members with more than six services), fidelity (DACTS), and outcomes (inpatient mental health admissions and rate and emergency room visits for substance use or mental health). Thresholds for "green" and "yellow" for each measure were created by an analysis of historical provider data, utilization data from other Magellan public sector sites that also offer this service, and Medicaid national averages. A total score is calculated for a biannual adjustment in the rate of pay for performance. Quarterly scorecards are disseminated as well to assist providers in tracking interim progress.

The initial rate adjustment scorecard represented data from June 1 through August 31, 2014 and was disseminated to providers in October. The first biannual adjustment scorecard was disseminated in April and represented data from December 1 through February 28, 2015. The scorecard has proven to be an effective quality management technique that has lead to improved outcomes for the LBHP's most vulnerable adult members. As a result of the scorecard, there was a 15.7% decrease in readmissions to the inpatient level of care, with readmissions declining from rate of 30.77% to 25.95%. Improvements could also be seen in the admissions per hundred. This metric declined from 19.59 admissions per hundred to 17.10. There was a 10.52% decrease in the average length of stay (ALOS), with days declining from 6.75 to 6.04. Of the twelve teams included in the scorecard intervention, eight showed decreases in readmissions and admissions per hundred, with one provider going from a 30%

readmission rate in the first scorecard to a 0% readmission rate in the second scorecard. Magellan will continue this intervention in contract year four.

B. Multi-systemic therapy (MST)

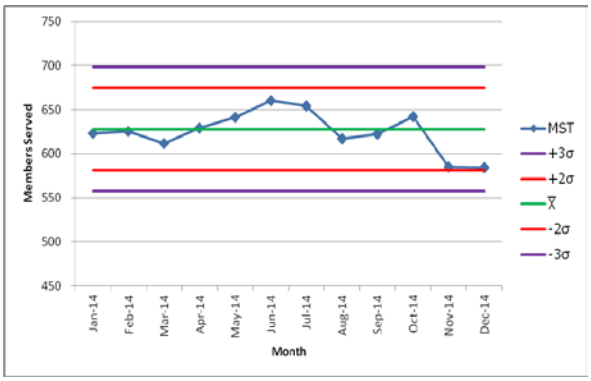
The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized interventions. MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. 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.
- 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. Magellan

implemented treatment record review monitoring to ensure adherence to quality documentation and record keeping practices in contract year three. There were 31 contracted MST agencies that served 2160 unduplicated members in calendar year 2014. In 2014, there was a mean of 627.9 members served. Utilization trends for 2014 stayed between one standard deviation from the mean with slight decline in November and December 2014. This is consistent with lower utilization of services seen during the holiday season.



C. Homebuilders

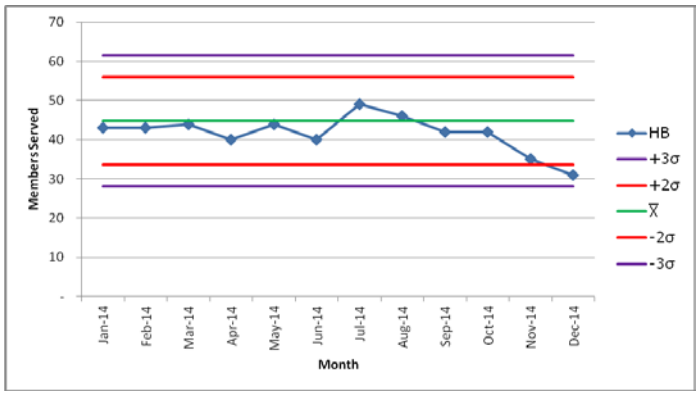
Homebuilders is an intensive, in-home Evidence-Based Program (EBP) utilizing research based strategies (e.g. Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (birth to 18 years) at imminent risk of out of home placement, 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. A Memorandum of Understanding was established to create a collaborative protocol for quality monitoring and report sharing. Magellan implemented treatment record review monitoring to ensure adherence to quality documentation and record keeping practices in contract year three. There were 17 contracted HB agencies that served 298 unduplicated members in calendar year 2014. There was a mean of 44.8 members served. Utilization trends for 2014 were flat for most of the year with a slight decline below one standard deviation in December 2014. This is consistent with lower utilization of services seen during the holiday season.



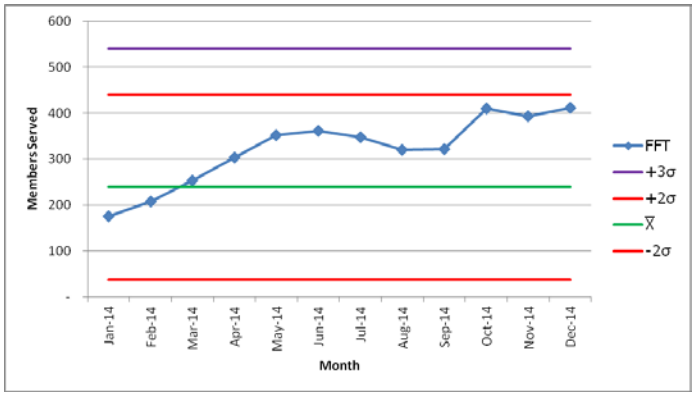
D. Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is an evidenced based 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 skills, and increase the family's ability to access community resources.

Beginning August 2013, a collaborative relationship was formed with the fidelity oversight agency, Functional Family Therapy, LLC (FFT, LLC). A Memorandum of Understanding was developed that established a collaborative protocol for quality monitoring and report sharing. Magellan implemented treatment record review monitoring to ensure adherence to quality documentation and record keeping practices in contract year three. There were 21 contracted FFT agencies that served 1250 unduplicated members in calendar year 2014. This represented an increase of 96.0% from 2013 in which 639 unduplicated members were served. There was a mean of 239.0 members served. Trends showed consistent upward utilization of FFT, despite seasonality. This can be attributed to Medicaid rules that were modified allowing CSoC children to have access to this level of care. There are no other EBPs that can be provided simultaneously while eligible for the CSoC program.



E. Other EBP Initiatives

The Louisiana Unit continues to actively work to improve the clinical program for 0- to 6-year-old members. During contract year three, Magellan continued working closely with the LSU Health Sciences Center and Tulane Medical Center 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 the following:

- CPP: Three training periods (a total of 7 days of training) plus supervision/consultation for 18 months following the initial training sessions.
- PMT: Three training periods (a total of 5 days of training) plus 24 supervision/consultation calls one every other week.

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 Louisiana Unit 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, 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. In order to become a certified trained CPP Therapist, providers must participate in 18 months of training and phone consultations. Training costs, including training materials are 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 offered 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 two-day training session followed by the next two-day training session 1 month later, twenty-four 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. Training costs, including training materials are covered by Magellan and Tulane Medical Center.

XVII. Behavioral Continuum (System Transformation)

In addition to the traditional managed care pieces of our organizational approach, Magellan has implemented a system transformation component to our work in Louisiana. This has been critical to help make the State's vision a reality through the development of collaborations across agencies and stakeholders, the development of best practices and sharing of expertise in recovery resiliency, wellness, as well as peer supports and cultural competency and the ongoing bridging of stakeholders in the nascent system to bring partners together for improved member outcomes. Magellan is dedicated to transforming and improving the landscape of how behavioral health services are provided to members of the LBHP. The Louisiana Unit System Transformation Department conducts a multitude of programs and initiatives to continuously improve the service 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, 2015, the CSoC program served approximately 4,351 individuals. There has been an increase of 30.93% in current enrollment when comparing end of year data for each contract year.

Region	2/28/2014	2/27/2015	Increase
Region 1 – Orleans/Jefferson area	246	300	54
Region 2 -Baton Rouge area	221	263	42
Region 3- Covington area	---	62	62
Region 4 – Thibodaux area	---	54	54
Region 5 – Lafayette area	---	32	32
Region 6 – Lake Charles area	---	29	29
Region 7 - Alexandria area	151	179	70
Region 8 –Shreveport area	211	220	9
Region 9 - Monroe area	238	258	20
Total	1067	1397	330

During contract year three, 63.07% of enrolled children were male and 36.72% were female. Of those reporting, African-Americans represented 60.84% and Caucasians represented 27.79% of all enrollees. Breakdown of children/youth enrolled by age is as follows: ages 2-8 (15.15%), ages 9-14 (48.74%), ages 15-17 (28.87%), ages 18-21 (7.03%) and Unspecified (0.21%). Population of focus: ages 12-16 represented the majority of those served (49.84%). CSoC Regions 1 and 9 represented 44.4% of the children currently enrolled. The four most frequent referral sources for the CSoC program were, in order, Licensed Mental Health Professionals, Other, Hospitals, and Caregivers. The "Other" category can include individuals such as neighbors, friends, relatives, etc. that are not specified in a category. The next three highest admission drivers were: School personnel, Department of Children and Family Services and the Office of Juvenile Justice. The mean length of stay for the children/youth in the CSoC program that were discharged in the second year was 329.83 days. Reasons for discharge can be due to successful completion of the 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 (30.8%);
2. Oppositional Defiant Disorder (9.5%) and,
3. Unspecified hyperkinetic syndrome (8.9%).

These three diagnoses accounted for 49.2% 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 D Coordinated Systems of Care (CSoC) Quality Assurance Performance Measures** 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, the most significant increases in utilization were demonstrated in both Parent Support and Youth Support Services. IL/SB and STR utilization remained steady with a slight dip in STR utilization in the last quarter. Crisis Intervention, Community Psychiatric Supportive Treatment (CPST) and Psychosocial Rehabilitative Services (PSR) continued to show strong and significant growth. Crisis Stabilization remained unavailable in the network due to various ongoing systemic barriers. Data indicated that 93.51% of CSoC children and youth utilized natural and informal supports during enrollment and a reported 94.72% of members utilized natural and informal supports after discharge from the Wraparound agencies.

To assess the effectiveness of the CSoC program in reducing out-of-home placements since March 1, 2012, outcomes data showed a 16.51% decrease in the number of CSoC children and youth who had restrictive placements prior to enrollment in Wraparound services (32.44%) to the number of CSoC children and youth who had a restrictive placement setting after enrolling in Wraparound services (15.93%).

Educational outcomes data should be interpreted cautiously since report card periods are not standardized across school systems and the collection of performance and conduct data across school districts is inconsistent, and 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 capture accurate school performance data from sources that are standardized, consistent, or fully reliable.

The CSoC program continued the Performance Improvement Projects (PIP) for Year 3. Outcome summary demonstrates 99.92% of CSoC children received some form of service authorization (CSoC + other) and 95.94% of authorized members received a claim for CSoC services. Please see **Section V Quality Improvement Activities and Performance Improvement Projects** for further details.

Process improvements implemented in the second contract year include the implementation of a revised CSoC QI Data tracking spreadsheet, additional automated reports, electronic submission of the

Child and Adolescent Needs and Strengths (CANS) assessments, distribution of a monthly service delivery claims database report for all Wraparound agencies and the Statewide Family Support Organization and a quarterly CSoC Scorecard for the Wraparound agencies. These interventions provided more opportunities for additional data drill down and therefore, improved outcomes reporting. The 2nd Annual 1915(c) HCBS Waiver training and CSoC QI/QM conference was held for WAA Executive Directors, QI Managers, Program Managers, Clinical Supervisors and the SFSO Leadership staff that provided an in-depth training on waiver guidelines and focused on data collection and submission processes, appropriate use of data assistive tools for monitoring service delivery, the critical nature of maintaining data integrity for performance measure tracking and outcomes reporting. The QI Data Spreadsheet underwent revisions and technical improvements that aided the WAAs in data collection and submission. Targeted trainings for the Wraparound agencies, including the four new CSoC regions and the Statewide FSO, community providers and members were held throughout the year that improved knowledge of 1915(c) and (b3) Home and Community-Based Services, authorization processes, claims submission processes and overall utilization of services for CSoC members. Other outreach and training efforts are:

- 0-6 Mental Health Initiative: Child Parent Psychotherapy Training and Parent Management Training – Magellan-funded training of 3 provider cohorts for geographic coverage of the state.
- Applied Suicide Intervention Skills Training (ASIST) – a 2 day suicide first aid training program.
- SuicideTALK – suicide awareness/prevention training (90 minutes to 3 hours).
- MHFA – Mental Health First Aid training – previously conducted by Recovery/Resiliency staff, now planned to be conducted by Children's staff for SFSO staff.
- Seed Grants – Magellan-funded grants for small projects.
- "Warm Line."
- MY FEST – Youth festival held in 2013 and 2014, attracting 40 vendors/exhibitors, and over 1200 youth from around the state.
- Youth Day at the Capitol Event.
- MY LIFE (Monthly youth groups in as many as 3 locations around the state: Baton Rouge, Shreveport, Hammond).
- Transition to Independence Process (TIP) Model Training (2 cohorts of trainees from multiple agencies, with model later adopted by SFSO for implementation).
- Parent Empowerment Conference.
- Building Bridges Initiative.
- Sponsoring events such as BLAST in Opelousas, Jefferson Wellness Summit, Learning Disabilities Conference in Baton Rouge, etc.
- Crisis Intervention Training (conducted in locations around the state for first responders in areas of identified need).
- Numerous presentations to LEAs on "Increasing Behavioral Health Services in Schools."

- Numerous court appearances around the state to support judges and court staff in navigating the LBHP service array and CSoC.

Many of the items listed above are not deliverables, but value-added, Magellan –funded contributions made to enhance the overall program and to address member and stakeholder needs. The CSoC Scorecard was implemented during this third contract year. With this intervention, Wraparound agencies received quarterly data on 13 separate performance measures which included: 11 PMs on utilization, 1 PM on Plan of Care compliance and 1 PM on Wraparound fidelity compliance; for their respective regions and the CSoC aggregate data for the program were included.

Network Development and Highlights

Network development has remained critical to the success of CSoC. The expansion of the CSoC program on 11/20/2014 included 4 new regions and successfully launched the program statewide. This network growth expanded the 5 specialized 1915(c) HCBS waiver services statewide as well. Highlights of these expansion efforts are listed below and each required extensive collaboration between the Network and CSoC Departments to address training and outreach and to find solutions for unmet needs.

- Completed analysis to OBH for recommendation to open crisis stabilization to all children and pursue the opportunity to utilize TFC for Crisis Stabilization.
- Continued recruitment efforts for crisis stabilization and short term respite. Meetings with several providers sharing detailed information on the services. Currently, providers have not moved forward until it is confirmed that this service will move under the state plan amendment.
- Administrator login set up in mp.com for WAA enabling them to add users for Electronic CANS submission.
- Outreach to all CSoC providers in the New CSoC implementing regions who had initially contracted for the 5 specialized levels of services.
- Organized Provider Forum(s) and CSoC training(s) for the new regions.
- Coordinated with recruitment the ad hoc agreements for Certified Providers (CPs).
- Provided ongoing claims training for CPs and other CSoC providers.
- Scheduled collaborative meetings between service provider agencies and WAAs to improve communications and relationships and gain a mutual understanding of roles in the Wraparound process.
- Continued technical support for the Statewide Family Support Organization (SFSO) for accurate claims submissions and SFSO had a strong increase in utilization of both youth and parent support services during this CY.
- Partnered with state agency (DCFS) to obtain their list of qualified Short Term Respite providers from which to recruit for the network.

CSoC Network Challenges

- Crisis stabilization licensing rules (e.g. high cost, loan requirements) continued to make it difficult for providers to embark on starting this type of provider agency given the small number of youth eligible in individual regions and the number of members needing service at any one time.

The following chart shows data up to March 2015 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.

CSOC Service	Crisis Stabilization	Independent Living/Skills Building	Parent Support & Training	Short Term Respite Care	Youth Support & Training	Total
Region 1	0	34	1	2	1	38
Region 2	0	11	1	1	1	14
Region 3	0	6	1	0	1	8
Region 4	1	4	1	1	1	8
Region 5	0	12	1	1	1	15
Region 6	0	8	1	1	1	11
Region 7	0	12	1	1	1	15
Region 8	0	12	1	0	1	14
Region 9	0	15	1	3	1	20
TOTAL	1	114	9	10	9	143

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 Gulf Opportunity Zone (GO-ZONE). The program's services were initially 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, Rita, Gustav, and Ike, with the vouchers being 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 service 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 managed the PSH program with eleven staff members dedicated to serve this population. Magellan successfully transitioned management of the housing supports and related functions to the Department of Health and Hospitals Permanent Supportive Housing office on March 1, 2015. From March 1, 2014, Magellan's PSH team received and processed 2,915 applications submitted by members. The total PSH population, housed and awaiting housing remained stable at 2,867 under Magellan management with 983 (34.3%) having moved from limited CDBG funding to sustainable funding sources. The PSH Team processed more than 1114 Independent Assessments and helped move a total of 913 members to Medicaid 1915(i) eligibility while actively managing the authorizations of all 2,867 members in PSH.

The utilization data for PSH from March 2014 to February 2015 were as follows:

- 2,867 total members in PSH Services.
- 2,760 total members housed.
- 34.3% total members migrated to sustainable funding.
- 12 Community and Provider trainings and outreach awareness events.

From Go Live to transition, the Magellan PSH processed more than 2,000 independent assessments and helped move 1,163 members to sustainable funding via the 1915(i) State Plan Amendment.

Magellan staff members were able to quickly build and maintain a knowledge base related to PSH, and to mold the PSH model within the LBHP. Magellan was able to effectively work with various stakeholders to develop the referral and lease up capacity to assure maximum utilization of the Permanent Supportive Housing program. Permanent Supportive Housing was on solid footing as it transitioned to the Department of Health and Hospitals.

C. Recovery and Resiliency

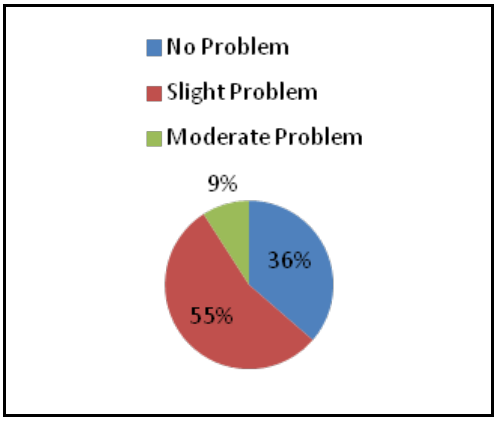
In contract year 2014-2015, the Louisiana Unit Recovery and Resiliency team continued the process of developing an infrastructure in Louisiana which valued and supported services driven by and for peers (also referred to as individuals with a behavioral health diagnosis). In addition to the work with peers in Contract years 1 and 2, family and youth voice and choice activities were also merged with the Recovery and Resiliency department to support the notion that peer support is a needed and beneficial service across the lifespan. Thus, through the merger of the peer, family and youth supports, comprehensive programs were developed and enhanced which focused on a variety of identified needs across the lifespan. The merger also placed a higher focus on the development of a recovery-oriented service culture which is based on the philosophy that recovery is attainable for peers, family members and youth and as such is integral to quality behavioral healthcare. Thus, 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 2014 and early 2015.

Seed Grant Initiative

The purpose of the Seed Grant initiative is to award micro grants to agencies to support the development of person-centered care modalities. In 2013, 23 grant applications were received and 7 grants were awarded which ranged in value from $1,500 to $5,000. Examples of initiatives supported included:

- Capital Area Human Services District employed a part-time Peer Support Specialist to work with individuals released from East Baton Rouge Parish Prison.
- Start Corporation expanded and enhanced wellness programs for peers served through the agency by focusing on creative exercise programs and healthy eating.
- ACER LLC implemented a co-occurring eating disorder group to focus on the needs of women with complex health needs. The agency was able to support 16 unique individuals through this initiative and as evidenced below was an instrument in supporting healthy relationships with dietary needs.



ACER, LLC 12 Week Post-Survey Results of women who attended eating disorder workshop, n=16. Pre-Survey indicated 100% of women with slight to moderate problem.

As the Seed Grant program has continued to evolve and expand it is apparent that agencies are invested in fostering recovery and recovery knowledge among populations served and in many instances combined grant dollars allotted with in-kind support to create long-lasting and sustainable change. No where was this clearer than in the third year of the Seed Grant Program in which submittal

of grant applications more than doubled with the receipt of 47 grant proposals. Among applications received, 8 grants were awarded in the amount of $5,000 to fund a variety of programs which include:

- Capital Area Human Services District received continuation funding to employ a Peer Support Specialist and to enhance service modalities to individuals released from East Baton Rouge Parish Prison,
- Northeast Delta Human Services Authority will host a conference focused on the needs of rural populations in Northeast Louisiana, and
- Volunteers of America-Central Louisiana to create and host a stigma-reduction campaign which will encompass outreach to rural populations.

As evidenced by continued growth in year 3, 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 and family 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 continued to expand in 2014 with an additional 4 groups in Baton Rouge and New Orleans. Moreover, the partnership with Capital Area Human Services District, which began in 2013, has continued and expanded to encompass groups in rural areas surrounding Baton Rouge. As such, a total of 14 groups have been started throughout the southern part of Louisiana during the life of the contract and over 60 peers have received training to manage Peer Support Whole Health and Resiliency groups.

Facilitator and Agency Development Program (FADP)

Originally developed as part of the PSWH and R program, the purpose of the Facilitator and Agency 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. In 2014, the program was expanded to fund scholarships for peers to expand opportunities to attend continuing education events and Magellan sponsored activities. Additionally, in early 2015, support for agencies was added to the program to aid in achieving long-term sustainability. Funds in 2014 and early 2015 were distributed to the following activities:

- Seed Grant Review committee which compensated peers to review and grade the Seed Grant applications in both 2014 and 2015. Thus, ensuring that member voice and choice was embedded in the process.
- Continuing Education Activities including the National Alliance for Mental Illness Conference, the Louisiana Association of Substance Abuse Counselors and Trainers and the Community Integration and Recovery Academy.
- Supporting peers as consultants to aid in the facilitation of Magellan sponsored trainings including Peer Support Whole Health and Resiliency.
- Supporting the long-term sustainability of peer organizations including the Louisiana Association of Peer Specialists and the DreamTrue Foundation through the payment of non-profit application fees.

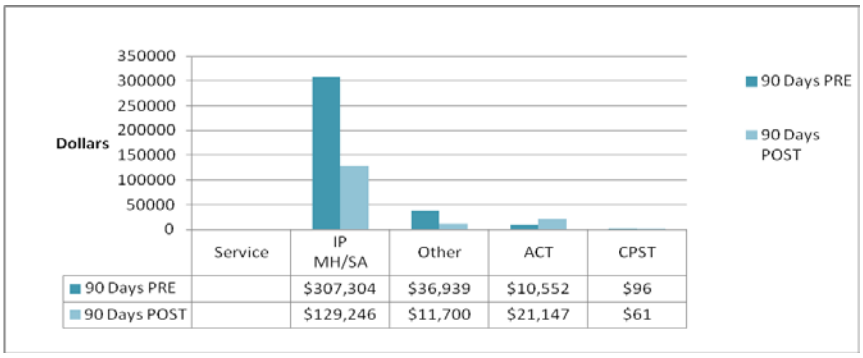
Peer Certification and Credentialing

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 in Louisiana formed a collaborative partnership to discuss opportunities to develop peer credentialing in Louisiana as an additional requirement in conjunction with the current Peer Support 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. Building upon the work regarding Peer Certification and Credentialing, Magellan Health and LASACT partnered in early 2015 to develop a series of Peer Support Specialist Ethics trainings to ensure peers received the required number of Ethics hours to meet the requirements to be grandfathered into the certification program. Ethics trainings are scheduled to begin in May 2015 and will extend through June of 2015 with the goal of reaching 150 peers and professionals in Louisiana.

Peer Support/Member Services

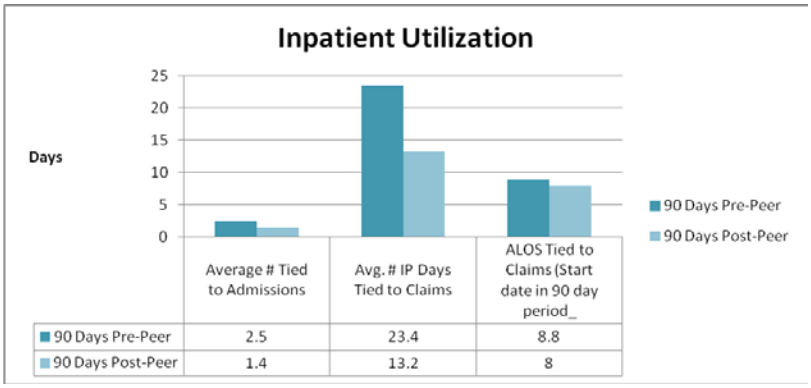
As part of Recovery and Resiliency (R and R) efforts in Louisiana, a Recovery Navigator is employed to perform direct member outreach and to serve as an external face of Magellan in Louisiana. The duties of a Recovery Navigator include the support of members in identifying and reaching long-term recovery and wellness goals and responding 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 and in 2014 she served 34 unique members in the maintenance of community tenure activities. As evidenced below, services

provided through the Recovery Navigation process result in lower costs of care and ensure that member needs are addressed in the least restrictive environment.



	Service	IP MH/SA	Other	ACT	CPST
90 Days PRE		$307,304	$36,939	$10,552	$96
90 Days POST		$129,246	$11,700	$21,147	$61

Peer Recovery Navigator Outcomes of 34 members served. Ninety days pre-implementation represent the cost per individual prior to peer navigation services and 90 days post-implementation represent the cost per individual post navigation services. Savings achieved approximately $190,000 as a result of peer services.



	Average # Tied to Admissions	Avg. # IP Days Tied to Claims	ALOS Tied to Claims (Start date in 90 day period_
90 Days Pre-Peer	2.5	23.4	8.8
90 Days Post-Peer	1.4	13.2	8

Peer Recovery Navigator outcomes of 34 members served. Inpatient utilization decreased 10.2 days as a result of the utilization of Peer Navigation Services.

Community Partnerships: Training and Education - The Recovery and Resiliency team continued to identify in 2014 partnerships and participated in activities that would expand the breadth and scope of peer and family knowledge across the state. For example, in 2014 the team partnered with the SAMHSA/National Center for Trauma-Informed Care to host a 2-day training focused on increasing, not only the knowledge of peers in working with and indentifying issues related to trauma, but also equipping peers with tools to support others in identifying and addressing needs related to trauma. As evidenced below, peers markedly improved their knowledge base regarding trauma-informed care as a

result of the training. Day 1 Trauma Informed Care Evaluation Results, n=13. Please note the maximum per training class is 15.

Community Integration and Recovery Academy (CIRA)

In November 2014, the R and R team organized the second annual CIRA, a two-day conference in Metairie, Louisiana. The purpose of CIRA was to continue the dialogue regarding the implementation of peer-centered services and how to create a recovery-oriented culture in Louisiana that was begun in 2013. The event featured national recognized speakers in the field of behavioral health including Thomas Lane and Charles Curie. During the course of the event, 125 individuals attended from across the state, approximately 75% of whom were representatives of the peer and family communities. In addition, 20 workshops were made available to attendees and focused on various topics regarding peer inclusion. Topics included:

- Community Integration
- Therapeutic Fables and Cognitive Behavioral Therapy
- Addressing Stress and Burnout
- Peer Support Specialist Ethics

Attendee evaluations acknowledged that the conference provided ample networking opportunities and enhanced their understanding of what entails a recovery-oriented system of care.

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 in 2014 include providing technical assistance and support to host a series of peer dialogues across the state. To date 4 events have been held with a minimum of 20 participants. In addition, Magellan provides financial support to LAPS for the purpose of becoming a stand-alone non-profit agency and participates on the LAPS board.

Warmline

A WarmLine is a person-centered, strengths-driven telephone support system which is staffed by individuals with lived experience. For the purposes of Louisiana's contract deliverables, the WarmLine began operations in 2013 through a contract with Start Corporation and was expanded in the last year to operate 7 days a week from 5:00-10:00PM. The support line focuses on after hours care when individuals would not have ready access to clinicians. In 2014, as part of Magellan's recovery and resiliency team efforts to ensure WarmLine sustainability, Magellan provided direct technical assistance and support to Start Corporation which included regular monitoring visits, biweekly calls to address any

issues that have arisen and distribution of promotional materials to community partners. As evidence of these efforts, from September 2014 to February 2015, the WarmLine has averaged 171 calls per month. Moreover, these services are proving to fill a fundamental need in the support system of individuals diagnosed with behavioral health issues. For example,

> *An individual had received information on the WarmLine through Magellan's various community activities and had called seeking a listening ear. The call was staffed by a Certified Peer Support Specialist who was employed through our collaborative partner Start Corporation. During the course of the conversation it became apparent the caller was struggling with aspects of life. As a result, the Certified Peer Support Specialist connected him to Start Corporation's Homeless Outreach program. Moreover, an individual from Start volunteered to transfer him from Lafayette to Houma to begin services the following day. The individual served is now in a transitional housing unit, on a waiting list for Permanent Supportive Housing and is on the road to recovery. Upon meeting the WarmLine Operator who aided in the connection to services the individual expressed his gratitude and thanks that he made that initial call for help.*

Youth Empowerment and Education

In late 2014, the youth, family and adult teams were combined to address at a minimum the recovery and resiliency needs of individuals across the lifespan which includes the utilization peer support and person-centered modalities. As part of the team's efforts towards enhancing recovery and resiliency the following activities were undertaken.

My Life

My Life is a youth empowerment program which serves youth between the ages of 13-23. As a value-added service, My Life has been operating in Louisiana since the inception of the contract in 2012 and has not only been maintained during that time but has grown through dedicated community partnerships with Ekhaya and the DreamTrue Foundation. These agencies and others have been instrumental in encouraging youth to attend and be a part of My Life. In 2014, My Life hosted groups in Shreveport and Baton Rouge on a monthly basis and reached on average of 30 youth per month. In January 2015, a My Life survey instrument was created and employed to capture better the youth voice and make changes to the My Life program thus ensuring the inclusion of the youth voice throughout the program.

My Fest

The purpose of My Fest is to bring youth and families to advocate for and celebrate youth empowerment. In 2014, over 2000 individuals attended the 2nd Annual My Fest event which featured

over 50 vendors and over 40 acts featuring youth. This was a significant increase from the first My Fest held in 2013 and serves as an example of the increasing visibility of youth and families with regards to behavioral health recovery.

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

During the second contract year, Magellan developed and implemented an action plan to move the state into compliance with the SPA. This included successfully launching the IA/CBCM Model across all regions of the state by October 1, 2014. Pathways Community Health, a not-for-profit community mental health center that provides a full continuum of mental health and addiction recovery services 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. To recap, the implementation schedule was as follows:

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	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

	Iberville LaSalle Natchitoches Orleans Plaquemines Pointe Coupee Rapides Red River Sabine Saint Bernard Vernon Webster West Baton Rouge West Feliciana Winn			Washington

Since implementation of the IA/CBCM process, there has been improved compliance with state and federal regulations with the 1915(i) SPA. In contract year two, there were 23 performance measures related to the 1915(i) State Plan Amendment that did not meet the 100% compliance standard. In contract year three, quarter four, only eight of the measures did not meet the 100% standard. Of those, five had compliance rates higher than 92% and only two of fell below the 86% threshold requiring system-wide corrective action plans.

Magellan has also seen improved outcomes related to members receiving services through the 1915(i) SPA. Readmissions for this group declined from 17.79% in contract year two to 15.73% in contract year three. This population also demonstrates significantly higher follow up after hospitalization rates when compared to the Adult Medicaid population. The Adult Medicaid population had a 7- day FUH rate of 27.65% and a 30-day FUH rate of 43.97. The 1915(i) population had rates above the HEDIS 50th percentile of 7-day and 30-day, 46% and 65% respectively. There rates were 48.3% for 7-day and 64.93% for 30-day.

XVIII. Member, Family Member and Stakeholder Involvement

A true "culture of quality" must be based on a solid QM strategy that is informed by an organization's Members and stakeholders. The design, implementation and evaluation processes must be a product of extensive local review and feedback. The Louisiana Unit actively recruits members, families, caregivers, providers, advocates, and local stakeholders to serve as members on all of its quality committees. Feedback from these individuals affords the committees unique firsthand experiences while adding depth and understanding to the evaluation process. These individuals help Magellan committees

identify and prioritize relevant information and ideas worthy of further design and pursuit. Stakeholder input helps the committee evaluate and understand quality findings and identify root causes that otherwise may not have been considered.

A. Communication with Members and Family Members

The Louisiana Unit 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. The FMASC currently has active involvement from member advocacy groups as well as a family member. In contract year three, Magellan actively recruited members for participation in committees (i.e., disseminated recruitment flyers to providers and advocacy groups); however, it has been difficult to maintain consistent involvement in committees. 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
- Member and provider grievances and appeals
- Member satisfaction survey results
- Policies and standards
- Magellan's member rights and responsibilities statement

Outside of the committee structure, Magellan utilizes several mechanisms to further communicate with our members. Member Handbooks were distributed to Wraparound Agencies for dissemination to members. Magellan distributes community updates and newsletters throughout the year and maintains a robust member webpage that provides valuable resources and communications to members. Members can access the Member Handbook, report grievances, and receive information on accessing services via the webpage. Examples of some of the materials and resources found on the webpage include:

- **Web-based Education and Support Resources.** Our MagellanofLouisiana.com website is designed for members, providers and other stakeholders and provides access to a comprehensive health and wellness library, as well as access to our comprehensive E-Learning Center that includes resources such as health literacy materials encouraging healthy living, our Peer Support Whole Health and Wellness e-newsletter archive, the opportunity to take e-courses on resiliency and recovery and peer support and other useful information. Members

can search for providers through our LBHP customized provider search function. As a result, website usage has consistently grown since 2012. In our February 2015 tracking report, we demonstrated monthly activity of 20,014 sessions (visits) and 9,354 users (unique visitors) and we have an average of 2.47 pages viewed during each visit.

- **Autism Resources.** Magellan provides resources exclusively for caregivers of children with autism, including access to www.MyAutismTeam.com, a social network and support group, and www.LoveMyProvider.com, a searchable directory of services and providers recommended by other caregivers. In Louisiana, we posted these resources on our website and promoted them through our community e-newsletter.

B. Communication with Providers and Stakeholders

Provider and stakeholder involvement are also key components 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

Magellan also facilitates communications with providers by offering a broad spectrum of resources to assist in obtaining information. Along with our provider relations and training activities, ongoing technical support, scheduled provider meetings, conference calls, webinars, and onsite support from our network, clinical, and quality improvement staff, providers will find a wealth of resources using our website at www.magellanoflouisiana.com, as well as the MagellanProvider.com Web portal, provider handbook, and provider newsletters. Post training surveys provide a continuous feedback loop, and responses are analyzed and inform ongoing Louisiana training and development activities. A summary

of available training resources is provided in the chart below:

Training Type	Specifics
Dedicated Louisiana Provider Relations Liaison Supports Provider Training	Magellan has a dedicated Provider Relations Liaison (PRL) focused on meeting the training needs of Louisiana providers. Training activities are guided by our Louisiana specific provider training plan as well as the CSOC training plan and delivers ongoing training programs to all providers. The PRL is also available to design and deliver training based on the specific needs of and requests from providers. Support includes face-to-to face or webinar delivery of training programs.
New Provider Orientation	Following the initial orientation sessions, we will determine, in conjunction with DHH-OBH leadership, the need for additional orientation. Throughout the contract term we will offer training opportunities that will benefit the overall delivery system. Some of the topics covered in our new provider orientation session include: an introduction to the LBHP, verification of member eligibility, claims submission and claims resolution, authorization and claims reports, the Louisiana Dashboard, MP.com, CA, provider search on Magellan's Louisiana website.
Regular Provider Meetings	On the third Thursday of each month Magellan hosts an all-provider call. This conference call allows Magellan to conduct focused training and share information with the Louisiana provider community. Each meeting has an agenda which is shared in advance with providers on our website. Each meeting allows for a provider question and answer period. Prior to each meeting, providers have the opportunity to submit agenda topics using their assigned PRL, e-mail, or our website. Material from these meetings is posted to our website so that providers always have easy access for future reference.
Ongoing Technical Assistance	Technical assistance needs are identified during day-to-day contact with providers, and technical assistance can be conducted with individual providers or through provider forums, newsletters, mailings, online tutorials, or electronic provider notices. Our Louisiana network team works in the community and provides an ongoing communication link with all providers. Providers are also supported by the Louisiana based staff. Providers have access to Magellan staff members knowledgeable in the Louisiana program 24/7/365. The Network Strategy Committee (NSC) also serves as a communication vehicle between the provider community and the larger LBHP program.
Regional Provider Discussion Meeting	As the LBHP continues to mature, Regional Provider Discussion Meetings are valuable to both providers and Magellan. Provider collaborations create opportunities for sharing of successes, lessons learned and efficiencies realized. Magellan Network team members are present at each discussion. These discussion meetings are a time for sharing and collaborating, not only with Magellan but also between providers from the community.
Provider Site Visits	Magellan PRLs visit providers at regular intervals, address operational issues, and make sure that communication lines remain open.
E-learning – Relias Essential	Magellan offers e-learning courses to providers through our partnership with online training resource, Essential Learning. Providers view this as a valuable service, particularly for those in rural areas who have difficulty attending workshops or conferences in person. There are nearly 500 courses to choose from including courses in addiction, developmental disabilities, computer skills, children services, and many other areas. There are also video workshops and conferences. Providers obtain continuing education credit for each course they take and as a Magellan network provider this service is offered at no charge. Providers currently have access to Magellan's Achieve application for certification training.
Provider Handbook	Magellan's DHH-OBH approved provider handbook is available on the provider website. Printed copies of the handbook are available for distribution upon request.
E-mail Blast Notifications	Magellan uses e-mail blast technology to communicate information to the Louisiana provider community for general notification updates, upcoming training events, and other important information as appropriate. Examples of recent e-mail blasts include the fax process for authorizations, CPT code changes, provider rate changes, and Case Logix announcement.
Provider Newsletter –	In addition to a monthly provider newsletter specific to LBHP, Louisiana providers have access to

Training Type	Specifics
Provider Focus	*Provider Focus*, Magellan's national quarterly provider newsletter. The newsletter includes articles by clinical professionals covering both mental health and substance use topics. The newsletters are posted to Magellan's Louisiana website.

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 with DHH-OBH;
- Submission of monthly, quarterly, semiannual, and annual reports on RFP and IMT deliverables;
- Participation and involvement in all Magellan quality committees; and
- Participation in CSoC Governance Board, Youth Interdepartmental Monitoring Team (IMT) and Adult IMT.

XIX. Satisfaction Surveys and Grievances

A. Member Experience of Care Survey

The member satisfaction survey is a key component of our quality program. Member satisfaction surveys remain the most direct measure of assessing the member's perceptions of quality and outcome of care. Gathering Member input and feedback allows us to continuously improve our processes to become more effective as well as to learn the needs of those we serve in order to improve the member experience of care. The Louisiana Unit 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. Youth and adult versions are used to address the unique needs of the each population subset. The survey responses are based on a balanced scale with a neutral middle for most questions.

The sampling approach included all members that received services during the selected sample period, minus those that have been previously surveyed by Magellan within the same year. Eligible clients need to meet the following criteria:

- Adult Group - age 18 or older and Youth Group – under 18 years of age as of sample frame dates;
- Are an enrollee in a state Medicaid program; and
- One or more claims or have one or more authorizations to either mental health services or substance use services during the time period of the sample selection.

In 2014, all clients who requested treatment between (07/01/2014 - 09/30/2014) who had not been surveyed during the previous twelve months were selected for the sample. To meet the acceptable statistical requirements for a Power of .80 and a precision level of 95% confidence interval with a margin of error of +/- 5 percent, at least 385 respondents were required. An assumption of an approximate 15 percent response rate was used to complete the calculation of the sample. The response rate for the contract year three administration was 13.0% (n=573), which was a slight improvement from the contract year two response rate of 12.6% (n=556). The 2014 response rate met the statistical requirements for a valid sample size.

Data for the survey were collected using a mail-out and mail-back. The first mailing (12/18/2014, 12/19/2014) included the cover letter prepackaged with the client satisfaction questionnaire, and a business reply envelope. Approximately 21 days after the first mailing, a second mailing (01/8/2015, 01/9/2015) with a follow-up letter along with another client satisfaction questionnaire and a business reply envelope was sent to those clients who had not yet responded with a completed questionnaire or by means of returned mail. The survey response period was closed approximately 30 days after the second mailing (02/9/2015, 02/10/2015). 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 previous administrations.

Magellan Member Experience of Care (Combined Adult and Minor)

	CY1		CY2		CY3		
	Number of Responses	% Positive	Number of Responses	% Positive	Number of Responses	% Positive	# I Don't Know
If you contacted Magellan, how satisfied are you with the help you got to connect with the services you needed?	333	80.2%	492	82.4%	508	**81.7**	24

If I had other choices, I would still get services from this provider(s).	543	81.8%	547	82.0%	567	**81.2**	26
I would recommend this provider(s) to a friend or family member.	554	81.6%	547	85.5%	567	**83.4**	23
Staff was willing to see me as often as I felt was necessary.	538	83.3%	549	85.8%	566	**85.7**	19
I was able to get all the services I thought I needed.	547	80.3%	544	78.1%	556	**80.7**	14
I was able to see a psychiatrist when I wanted to.	532	74.6%	541	76.2%	560	**74.5**	50
I felt comfortable asking questions about my treatment and medication.	555	89.2%	550	88.5%	563	**88.7**	13
I felt free to complain.	542	72.8%	548	81.0%	562	**81.1**	16
Staff members believe that I can grow, change and recover.	511	83.2%	544	82.6%	566	**83.7**	50
Staff members helped me get the information I needed so I could take charge of managing my illness.	533	78.4%	538	79.3%	556	**80.9**	32
I deal more effectively with daily problems.	544	63.1%	536	67.1%	548	**65.6**	21
My symptoms are not bothering me as much.	537	53.1%	535	58.1%	546	**51.2**	24
Overall, my satisfaction with the services and treatment I received was:	544	82.5%	517	84.5%	533	**83.1**	

As an integral component of our overall QM Work Plan, our Louisiana QM team assesses survey data to compare performance against targets as well as identify and prioritize areas for potential performance improvement. Raw data responses are categorized as positive or not positive, and the difference in the proportion of positive responses for each question is evaluated by Pearson's chi-square statistic. A statistically significant result for the chi-square test (p-value less than the significance threshold, a = 0.05) indicates that there is significant difference of positive response between years, and a signal for further investigation of differences between administrations (e.g. seasonality, being on track for annual targets).

The performance guarantee goal for overall satisfaction was to not show a decline in the rate established in contract year one (82.5%). The rate for overall satisfaction in contract year three was 83.1%, which exceeded the goal by 0.6 percentage points. This represented a decline of 1.4 percentage points from contract year two. Although there was a decline, the decline was not considered statistically significant. Magellan sets an internal corporate goal of achieving at least 80% satisfaction for each element. There were 13 elements that fell below this threshold in contract year two. In contract year three, only ten elements did not meet the goal of 80% satisfaction. There was only one element (i.e., Q32: My symptoms are not bothering me as much) that showed statistically significant decline (a=0.024) between contract year two and three administrations. No elements showed a statistically significant change between contract year one and three administrations. Further analysis of

elements that did not meet 80% threshold indicate that only three measures were under the 80% goal when combining both positive and neutral response. See chart below for identified opportunities for improvement for 2015.

Question		CY3		
		Number of Responses	% Positive	% Positive and Neutral
Q13	I was able to see a psychiatrist when I wanted to.	560	**74.5**	**84.9**
Q18	My cultural preferences and race/ethnic background were included in planning services I received.	552	**74.2**	**91.2**
Q23	I, not a staff member, decided what my treatment goals should be.	550	**75.8**	**88.5**
Q25	I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	555	**72.3**	**85.5**
Q26	I deal more effectively with daily problems.	548	**65.6**	**85.1**
Q28	I am better able to deal with crisis.	550	**56.7**	**79.5**
Q29	I am getting along better with family.	551	**61.3**	**83**
Q30	I am more comfortable in social situations.	546	**57.6**	**81**
Q31	I do better in school and/or work.	532	**53.7**	**75.8**
Q32	My symptoms are not bothering me as much.	546	**51.2**	**75.7**

The appropriate QM committee reviewed any deficiencies or potential issues, and a designated work group was created and implemented interventions. Magellan distributed a survey summary report to DHH-OBH as well as to members and other stakeholders through the committee structure. One intervention established for 2015 is to disseminate the satisfaction survey data to providers with an emphasis on elements below 80% threshold. Magellan will also develop a training module on person centered treatment planning to increase provider awareness of the importance of member involvement in the treatment planning process. It is believed that continuous and ongoing involvement of members in the development and maintenance of a treatment plan will have a positive impact on the member's perception of improved outcomes. It is believed ongoing reviews of the treatment plan with members will allow providers to evaluate members' perceptions of improvement and make necessary changes if improvements are not perceived. Magellan also monitors members receiving services through the 1915(i) State Plan Amendment and the 1915(c) and (b3) Waivers to ensure that plan of care reviews occur 90 days after the POC development and semi-annually or annually as required by federal regulations.

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. The sampling approach included all participating providers who received at least one authorization or submitted a claim for service

between January 1 and June 30, 2014. Providers' contact information was drawn from Magellan's Integrated Provider Database (IPD). Data were collected via questionnaires that were distributed by e-mail or postal mail with an option to return them by mail or fax. Additionally, instructions were provided for online completion. The initial mailing was sent on September 12, 2014 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 October 6, 2014. 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 November 7, 2014, approximately 30 days after the second mailing. The response rate for the contract year three administration was 25.5% (n=105), which was a slight improvement from contract year two's response rate of 24.7% (n=101). The following chart outlines a sample of questions with comparison to previous administrations.

	CY1		CY2		CY3	
	Number of Responses	% Positive	Number of Responses	% Positive	Number of Responses	% Positive
Overall satisfaction with the services provided by Magellan	39	74.4%	89	87.6%	81	87.7%
Timeliness of answering your call or contact	48	70.2%	101	82.3%	104	87.0%
Availability of clinical staff	48	75.7%	100	85.3%	104	87.8%
Consistency of decisions by clinical staff	46	67.7%	101	74.3%	102	82.9%
Timeliness of communicating authorization decisions to you	46	69.4%	100	80.6%	104	87.8%
Access of care from providers in the network for your clients/patients in the timeframe you determined necessary	-	-	-	-	102	81.7%
Credentialing/Contracting process	46	82.6%	98	87.5%	104	90.8%
Authorization process	45	73.0%	99	81.4%	104	86.6%
Clinical appeals process	44	55.6%	98	58.8%	102	80.5%
Clinical appeals timeliness	44	55.6%	98	60.6%	102	80.5%
The professionalism of the clinical reviewer(s)	43	75.0%	95	84.6%	100	91.9%
If you have called or written to file a formal complaint, satisfaction with the ease and timeliness of Magellan's complaint resolution process.	42	50.0%	97	53.9%	93	69.2%
Accuracy of the processing of your claims by Magellan	40	74.4%	87	86.1%	99	89.9%
Claims appeals process	39	55.0%	88	68.4%	97	76.7%
Claims appeals timeliness	39	57.1%	87	71.8%	98	79.1%
Satisfaction with Magellan publications (i.e., provider handbook, Provider Focus newsletter)	43	88.4%	97	92.8%	95	92.6%

As with the member satisfaction survey, our Louisiana QM team assesses survey data to compare performance against targets as well as identify and prioritize areas for potential performance improvement. Raw data responses are categorized as positive or not positive, and the difference in the proportion of positive responses for each question is evaluated by Pearson's chi-square statistic. A statistically significant result for the chi-square test (p-value less than the significance threshold, a = 0.05) indicates that there is significant difference of positive response between years, and a signal for

further investigation of differences between administrations (e.g. seasonality, being on track for annual targets).

The performance guarantee goal for overall satisfaction was to surpass the rate established in contract year one (80.2%). The rate for overall satisfaction in contract year three was 87.7%, which exceeded the goal by 7.5 percentage points. This represented an incline of 0.1 percentage points from contract year two. Statistical analysis* indicated four measures showed statistically significant improvement from contract year one to contract year three administrations and one measure showed statistically significant improvement from contract year two to contract year three administrations. See chart below for details.

		% POSITIVE			% POSITIVE		
QUESTION		CY3	CY2	p-value	CY3	CY1	p-value
Q2	Timeliness of answering your call or contact	87.0%	82.3%	0.360	87.0%	70.2%	**0.017**
Q4	Overall satisfaction with calls made to Magellan (toll-free number)	85.5%	82.1%	0.535	85.5%	69.8%	**0.036**
Q8	Timeliness of communicating authorization decisions to you	87.8%	80.6%	0.208	87.8%	69.4%	**0.018**
Q13c	Clinical appeals process	80.5%	58.8%	**0.046**	80.5%	55.6%	0.057
Q17	Accuracy of the processing of your claims by Magellan	89.9%	86.1%	0.420	89.9%	74.4%	**0.025**
Q18	Timeliness of the processing of your claims by Magellan	85.9%	86.2%	0.945	85.9%	67.5%	**0.017**

Although there were no statistically significant declines, Magellan sets an internal corporate goal of achieving at least 75% satisfaction for each element to ensure continuous quality improvement. There were 8 elements that fell below the threshold in contract year two. In contract year three, only one element did not meet the goal of 75% satisfaction. The element (Q15: If you have called or written to file a formal complaint, satisfaction with the ease and timeliness of Magellan's complaint resolution process.) There has been a positive trend in satisfaction for this element, contract year one (50.0%) and contract year two (53.9%), with notable improvement in the contract year three administration of 15.3 percentage points from contract year two. It is important to note that only 17 providers responded that the measure was applicable to them. Of those who responded dissatisfied, none of them reported being very dissatisfied. Magellan discussed two barriers that could be affecting dissatisfaction. One barrier identified was providers could be unaware of established resolution timeframes and thus become dissatisfied due to unrealistic expectations. Another barrier identified was that provider grievances may not be recognized and/or captured by Magellan staff leading to dissatisfaction when Magellan does not respond. Magellan implemented interventions to improve satisfaction for this measure, including adding resolution timeframes to the acknowledgement letter template to increase provider awareness of resolution timeframes and disseminating refresher grievance training for Magellan staff to ensure grievances are being captured appropriately by frontline staff. The Provider Satisfaction Survey will not be conducted in 2015 in order to focus efforts on supporting providers through the transition of the contract to the Bayou Health Plans.

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, 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 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. 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 conducts quarterly audits on a sample of the grievance files to ensure that staff is following the established policies and procedures, correct letters are being used, and that files are compliant with all accreditation standards.

Magellan uses the data generated by the grievance management system to identify and address any trends or patterns in use or misuse of services, such as a disproportionate number of an individual type of grievance or a high or increasing number of grievances related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the appropriate committee conducts a root cause analysis and recommends interventions. This information allows the QIC to

quickly identify where to focus improvement efforts as well as implement program enhancements to increase the individual's ability to obtain needed services and achieve optimal treatment outcomes. We review this information continuously, so improvements to the system can be made on an ongoing basis. Individual grievance data, while maintained to manage the process of resolution and response, is not used in reporting or committee to protect Member privacy. If the Grievance Coordinator notes more than three grievances for the same provider, the issue is escalated to the QM team and reported to the Regional Network Credentialing Committee.

Additionally, Magellan investigates any quality of care concerns identified through quality audits or care management processes. Results are reported to the Regional Network Credentialing Committee for further action and follow-up. As needed, we work with providers to develop corrective action plans intended to address quality of care concerns. In all cases, action plans include a specific timeline for implementation of interventions, completion, and follow-up. Follow-up activities may include outreach to the provider to discuss their office processes, a random chart review, or an onsite visit. Evidence of serious quality of care issues found by the QIC can result in the immediate restriction or exclusion of the provider from network participation and may result in the reporting to the applicable State licensing board and national data bank.

Member Grievances

Magellan monitors grievances to ensure required timeframes for acknowledgement and resolutions are met. The Louisiana Unit received 147 member grievances during contract year three, which is comparable to the contract year two total of 136. During contract year three, the established timeframe for acknowledgement was three days and resolution was 90 days. Of the 147 grievances received, 100% were resolved within 90 days. The average resolution time for member grievances was 39 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 147 member grievances, 31 of them were filed by members with 1915(i) or 1915(c) eligibility, which represented 21.1% 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 10.3 days. In October, Magellan implemented internal trainings to reiterate waiver timeliness standards (14 day resolution timeframe) and established internal monitoring for grievances for waiver members to ensure timeliness is met. Since implementation of trainings, Magellan has achieved 100% compliance for resolving grievances for these populations within timeframes.

Magellan also thoroughly monitors the content of the grievances. Often times a grievance can involve multiple issues. Because of this, the total number of comment reasons is often higher than the total number of grievances received. In contract year three, Magellan received a total of 182 comment reasons for the 147 grievances received. The top reasons for member grievances were Quality of Care,

Quality of Service/Magellan, and Quality of Service/Provider. Grievances citing Access to Service did show a significant decrease in the third contract year (CY2: n=31; CY3: n=11), making this reason 6% of grievances, a significant decrease from last year's report of 22.8%.

Provider Grievances

The Louisiana Unit recorded and resolved 102 provider grievances, which represented a 39.7% increase from the contract year two (n=73). In contract year three, there was an increase in grievances related to Quality of Care reported by a provider, such as Wraparound Agency, regarding concerns related to other providers. Eighty of the 102 provider grievances (78%) were resolved within the Louisiana Unit standard timeframe of 30 days; however, the average resolution time for provider grievances was 22.6 days.

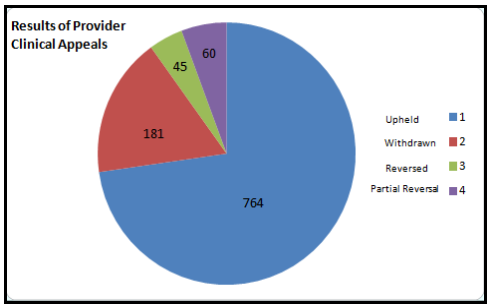
As with member grievances, there can be more than one reason cited for each provider grievance. There were a total of 130 comment reasons for the 102 provider grievances received. The top 3 reasons for provider grievances were Quality of Care, Quality of Service/Magellan, and Quality of Service/Provider. There was a 47% decrease in provider grievances regarding Care/Utilization Management and a 100% decrease (CY2: n=10; CY3: n=0) in provider grievances regarding Provider Management/Access issues when comparing the total comment reasons.

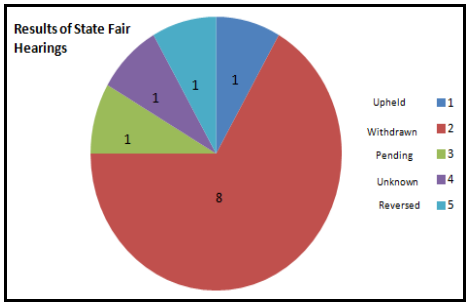
XX. Appeals Analysis

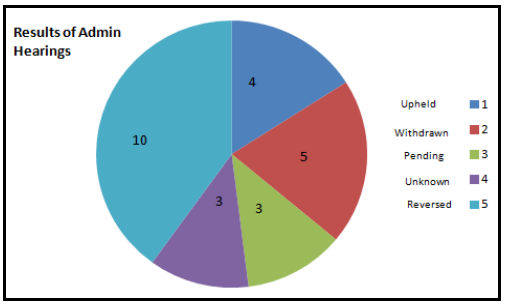
From a functional staffing perspective, to more efficiently deal with each particular type of request, clinical service determination appeals are overseen by the UM department. An appeal is defined as *a request for review of an action*. The Louisiana Unit will accept and document an oral request for an

appeal, explain the process, and inform the member or representative that the oral request must be followed by a written, signed request, unless the request is for an expedited resolution. When a request for an expedited resolution is received, staff accepts the request and resolves within three business days. Standard appeal requests are acknowledged within three business days and a determination is made within applicable timeframes. Appeals are documented and tracked in the Appeals and Retrospective Review Database. Members and providers are informed of their right to seek a State Fair Hearing if the Member is not satisfied with Magellan's decision in response to the appeal, and is walked through the process of doing so. Written communication templates are developed in compliance with DHH-OBH, regulatory, and accreditation requirements to include applicable appeals information inclusive of State Fair Hearing rights. All notices of action outlining the right to appeal and State Fair Hearing were modified this year to be in compliance with the Wells Lawsuit Settlement requirements as outlined and approved by the State. Specific information regarding Member grievance, appeal, State Fair Hearing procedures and time frames are also given to Members at the time of enrollment and to providers at the time of contracting. The UM Program places great emphasis on appeals data to identify both individual provider issues and potential systemic concerns. Each quarter, the Appeals Manager prepares a report with trended data for review. The report displays the appeals by type (standard or expedited) and percentage of appeals that meet the acknowledgement and resolution timeliness standard.

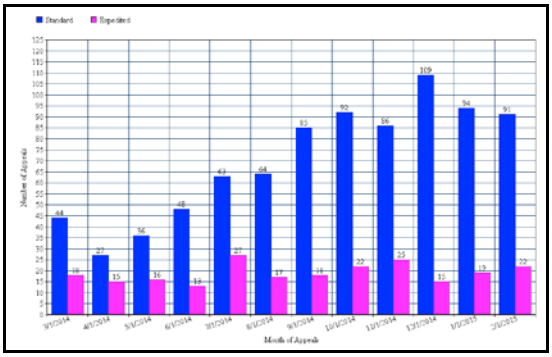
From March 1, 2014 to February 28, 2015, a total of 1050 appeals (839 standard appeals and 211 expedited appeals) were filed. Of the member appeals, 764 (83%) of the initial determinations were upheld, 60 (6%) were partially reversed, and 45 (8%) were reversed. In addition, 181 (3%) were withdrawn by 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 97% of expedited member appeals resolved within three (3) business days of the request. Twelve (12) of these required a state fair hearing. Of those, 1 determination was upheld, 1 was reversed, 8 were withdrawn, 1 is pending, and 1 determination is unknown. Twenty-five (25) of these required an administrative hearing. Of these, 4 determinations were upheld, 10 were reversed, 5 were withdrawn, 3 are pending, and 3 the determinations are unknown. The cases are considered withdrawn if the member or member representative, does not respond to the request for hearing. The cases are considered unknown if the Department of Health and Hospitals has not released the determination. The following graphs represent the frequency statistics for the clinical appeals.



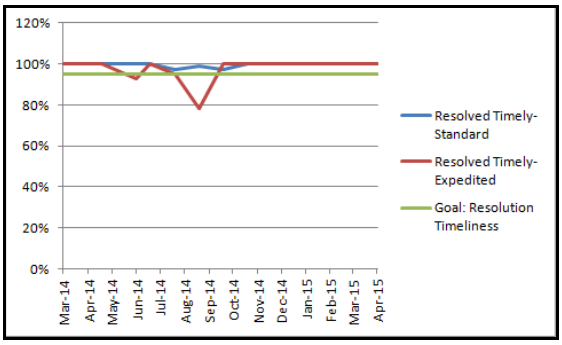




The next graph represents a comparison of the type of appeals received, or standard versus expedited appeals, from March 2014 to February 2015. The Louisiana Unit has consistently noticed an increase in member appeals from March 1, 2014.



The graph below represents the timeliness of resolution of member appeals. While there was noted variability in the timeliness of resolution, it should be acknowledged that in 9 of the 12 months shown, the resolution timeliness goal was met. Results below can be directly attributed to staffing issues and turnover in the Appeals department. In addition, holiday closures impacted the resolution time of expedited appeals. Hiring and training of staff was completed during October 2014, which resulted in positive improvements and a return to compliance in November. The Louisiana Unit will continue to look for and remove any barriers that may tend to preclude meeting the timeliness goal.



Magellan also tracks acknowledgment of appeals to ensure timeliness standards are met. Magellan consistently met the 95% compliance rate for acknowledgement with the exception of May and August of 2014. The decline can be attributed to staffing challenges and increase in number of receipts in the Appeals Department. Thresholds have been consistently maintained since September.

The Louisiana Unit 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. Magellan also implements robust internal auditing of appeal case records to ensure compliance with contract and accreditation standards. The results of the audits are reported and monitored by the QIC.

XXI. Provider Site Visits

The Louisiana Unit Network Department is responsible for assessing the quality, safety, and accessibility of office sites where care is delivered. The Louisiana Unit conducts site visits with providers as part of routine monitoring and credentialing activities. During contract year three, Magellan conducted 81 site visits as part of the credentialing process. All providers were found to be compliant with all review elements.

The Louisiana Unit conducted 89 onsite Treatment Record Review, Waiver Performance Measure and ACT Fidelity Audits in contract year three. Louisiana Unit QI staff reviewed record keeping and documentation standards to ensure it was complaint with quality standards. Please see **Section XIV Treatment Record Reviews and Clinical Practice Guidelines** and **Section XVI Evidence- and Best Practice Initiatives** for more information on these activities.

XXII. Accreditation and External Review

Magellan actively participates in both internal and external monitoring to ensure compliance with contract deliverables, federal regulations and corporate standards. The Louisiana Unit obtained full URAC Accreditation under Health Utilization Management Standards, Version 7.0 in January 2014, with an effective date through January 1, 2017. Magellan continues to conduct internal audits for appeals, grievances, credentialing, and personal files to ensure compliance with standards. Magellan will maintain URAC accreditation through the end of the contract.

IPRO was identified as the External Quality Review Organization (EQRO) for the Louisiana Unit by OBH. In contract year three, IPRO performed 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. The Louisiana Unit cooperated with all requests by IPRO and OBH and incorporated recommendations as part of its continuous quality improvement activities. Magellan will participate in a full compliance audit for contract year three in contract year four.

XXIII. RESOURCES

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

- Quality, Outcomes and Research Department which supports the Louisiana Unit 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 Louisiana Unit with data reports on several QI and UM indicators and provides consultation on report definitions and analysis.
- Network Services Department which supports the Louisiana Unit by verifying the accuracy of credentials submitted by providers for inclusion in the network.
- National Clinical Management Department which supports the Louisiana Unit through the development of 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 Louisiana Unit.
- 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 Louisiana Unit quality structure is comprised of specialty care and care management center committees. Unit 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 Louisiana Unit 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

XIV. DELEGATION

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

XXV. REGULATORY COMPLIANCE MONITORING

The Louisiana Unit 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, Louisiana Unit 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, and
- 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 ensuring understanding of those procedures and guidelines. 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.

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 in 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
- Molina (SURS)

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 allegations of fraud. 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 be 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 in Louisiana compliance department.

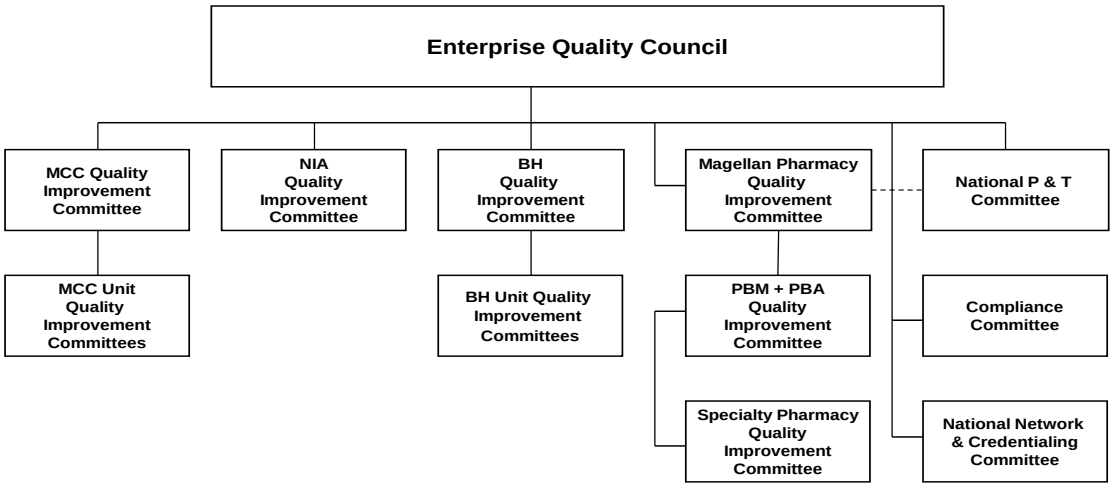
Magellan recognizes the increased complexity of protecting behavioral health recipient's privacy while managing access to, and the release of, protected health information (PHI) about behavioral health recipients in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security requirements. The Compliance Administrator also serves as the privacy officer and is responsible for the creation, implementation and maintenance of Magellan in 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, 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.

XXVI. SUMMARY

The Louisiana Unit's contract year three achievements and opportunities for improvement, as well as prioritized areas for focus in contract year four are outlined in the Executive Report on page 3. The contents of this report and documentation provided in the Appendices summarize Louisiana Unit's on-going QI activities, the trending of measures to assess performance, an analysis of improvements and an overall evaluation of the effectiveness of the QI and UM programs. The Louisiana Unit remains committed to on-going evaluation and improvement of care and services for members.

Appendix A. MH Enterprise Committee Structure

Quality Improvement Program Structure



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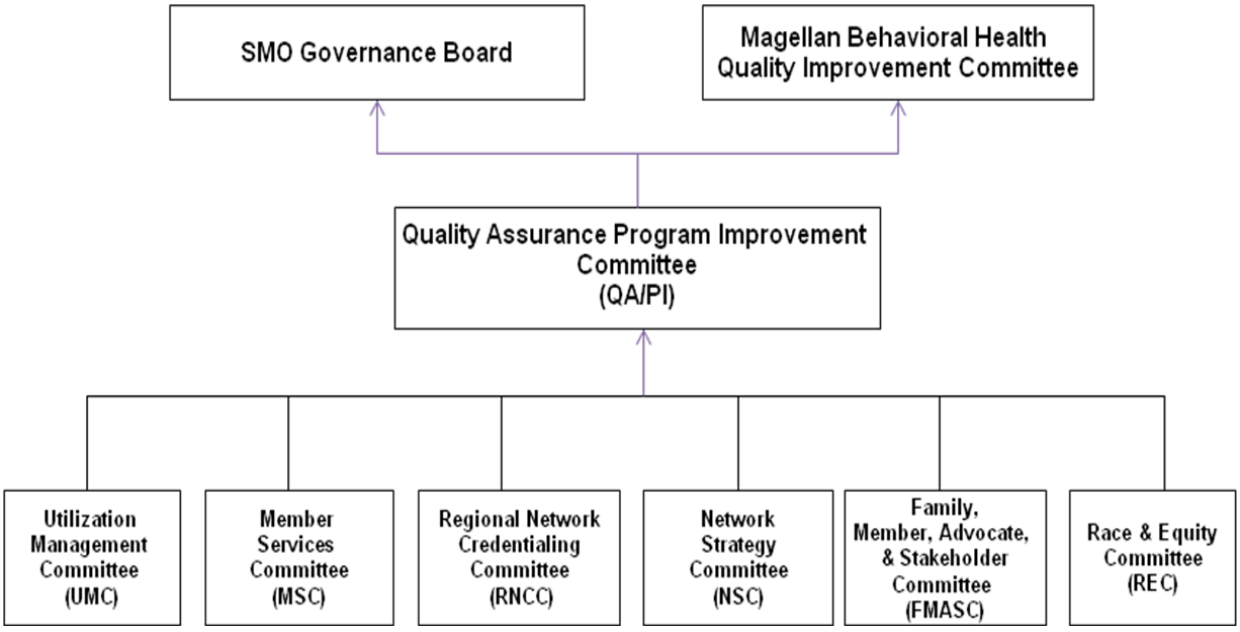
Louisiana Unit Quality Committee Structure



Appendix B. Staffing Grid Magellan Health

Resources Allocated to
Louisiana Unit
Quality Improvement Program

Resource allocation is evaluated based on the calendar year. The Louisiana Unit served a total of 168,469 unique members (unduplicated members with at least one claim received) during the calendar year 2014. This is a 4.27% increase over the number of members served in 2013 (n=161,570). The Louisiana Unit 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 2015 based on FTEs allocated to meet the needs of the QI program. Adjustments were made to account for de-implementation of contract ending in November 2015.

Louisiana Unit 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 (2)	25%
Supervisor Recovery and Resiliency Care Management	25%
Director Member Service	15%
Compliance Officer	25%
Quality Management Administrator	100%
QI Manager	100%
QI Clinical Reviewer (5)	100%
Member Grievance Coordinator	100%
Trainer	25%
QI Manager Reporting & Analytics	100%
Sr. Data and Reporting Analyst	100%
Ambulatory Follow-up Supervisor	20%
Network Administrator	20%
Network Coordinators (6)	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. Forty-six of the metrics have strict 100% compliance standards in order to meet federal regulations. Of those, 38 currently met the 100% compliance standard in contract year three quarter four. Eight of the PMs did not meet the compliance standard. Of the eight, only three fall below the 86% threshold and require system-wide corrective action plans. The remaining metrics require targeted provider remediation. 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						
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	
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	100%	In Compliance	

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.	86.05%	Not in Compliance	Deficient Providers were addressed for remediation. PM was above 86% so no systematic CAP was implemented at this time 3 Providers placed on CAPS to address; Internal trainings held with staff and provided further education on the importance of tracking authorization dates and CANS reassessment dates and how the two timeframes may not always align.
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	

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	99.83%	Not in Compliance	Only one member received a 1915(i) waiver service by a provider prior to meeting the LON requirements and receiving authorization. Magellan will continue to monitor to ensure compliance but no system-wide CAP is required.
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.	86.4%	Not in Compliance	Deficient Providers were addressed for remediation. PM was above 86% so no systematic CAP was implemented at this time. 1 out of 4 providers were required to submit CAPS to address deficiencies. 93providers were in compliance.
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.	100%	In Compliance	
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.	100%	In Compliance	

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.	100%	In Compliance	

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.	100%	In Compliance	

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.	100%	In Compliance	
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%	In Compliance	
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.	100%	In Compliance	

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%	In Compliance	

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.	100%	In Compliance	
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.	100%	In Compliance	

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.	100%	In Compliance	

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.	100%	In 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.	81.25%	Not in Compliance	Magellan has implemented a systematic CAP to address this measure. Magellan, in collaboration with OBH, changed methodology of data source in order to provide individual remediation actions when deficiencies are identified.
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.	96.2%	Not in Compliance	Deficient Providers were targeted for remediation. PM was above 86% so no systematic CAP was implemented at this time. 1 out of 4 providers were required to submit CAPS to address deficiencies. 3providers were in compliance.
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.	100%	In Compliance	

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.	92.4%	Not in Compliance	Deficient Providers were targeted for remediation. PM was above 86% so no systematic CAP was implemented at this time. 3 out of 4 providers were required to submit CAPS to address deficiencies. 1 provider was in compliance.
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.	100%	In Compliance	
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.	100%	In Compliance	
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.	24%	Not in Compliance	This PM was targeted for a systematic CAP. Interventions include targeted trainings for HCBS providers and continued auditing.
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.	75%	Not in Compliance	This PM was targeted for a systematic CAP. Interventions include targeted trainings for HCBS providers and continued auditing.

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.	100%	In Compliance	
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.	96%	Not in Compliance	Deficient Providers were targeted for remediation. PM was above 86% so no systematic CAP was implemented at this time. 1 out of 4 providers were required to submit CAPS to address deficiencies. 3providers were in compliance.

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. The date parameters for contract year 2 represent March 1, 2013 – February 28, 2014 and contract year 3 represents March 1, 2014 – February 28, 2015. When possible, aggregate comparisons between contract years will be provided. If not, time parameters for the data will be indicated for each metric.

QA Report 1: Appointment Access/WAA Fidelity

A. **Total # of days from initial date of authorization to date of first billable service. (i.e., Emergent, Urgent and Routine Appointment Access).** Data to be used for determining baseline timeframes: Emergent = within 1 hour; Urgent = within 48 hours and Routine = within 14 calendar days. Corporate access standards for Emergent, Urgent, and Routine goals are:
    - Emergent: 95%
    - Urgent: 95%
    - Routine: 70%

CY2			
Service Risk Level	**Volume**	**Average Days to Service**	**Percent In Range**
ROUTINE	3612	73.96	45.43%
URGENT	1151	10.51	55.95%
EMERGENT	23	12.70	73.91%

CY3			
Service Risk Level	**Volume**	**Average Days to Service**	**Percent In Range**
ROUTINE	5812	29.25	49.76%
URGENT	399	2.88	89.22%
EMERGENT	2	0.00	100.00%

Much improvement was seen in both the Urgent and Emergent service delivery percents in range between CY2 and CY3. Barriers to appointment access for routine levels of care included: member's lack of follow through in making appointments for various reasons (i.e. no transportation, noncompliant, etc.) or provider agency issues (i.e. waiting lists, in some locations the specific provider type may be geographically farther away than expected, etc.) Please see formal PIP Improve Member Access to Emergent, Urgent, and Routine Appointments in Section V of the Program Evaluation for interventions implemented to improve access.

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

- **CY2: 24.1 days**
- **CY3: 18.3 days**

There was improvement noted between the two contract years. During CY3, two different circumstances impacted the number of days between a brief CANS and a referral to a WAA:

1) Some of the original five CSoC regions met 240 capacity and referrals received by Magellan for those regions were initially sent to Resiliency Care Management (RCM) department before referral to a WAA and this accounted for longer number of days between brief CANS and referral to WAA. As soon as a position became available within the specified WAA region, the referral was sent to the WAA.

2) As of 11/20/14, four new CSoC regions joined the CSoC program. All referrals that screened eligible for CSoC with a brief CANS for those regions up to 30 days prior to start date, 10/22/14- 11/20/14, were referred to the WAA which would also impact the number of days between a brief CANS and a referral being sent to the WAA. Despite these circumstances that could have negatively impacted the mean number of days between a brief CANS and a referral to a WAA, a reduction in mean days was observed because of daily communications between the WAAs and the Magellan CSoC team about enrollment and discharge numbers.

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

- **CY2: 6.0 days**
- **CY3: 6.3 days**

Magellan's Enrollment Management process for each region is outlined below providing additional drill down of enrollment activities.

ENROLLMENT MANAGEMENT (CY3)	
REGION	

1	Total capacity = 320. As of 2/27/15, 300 members were enrolled and 16 members are pending enrollment.
2	Total capacity = 270. As of 2/27/15, 263 members were enrolled and 7 members are pending enrollment.
3	Total capacity = 240. As of 2/27/15, 62 members were enrolled with 22 members pending enrollment.
4	Total capacity = 240. As of 2/27/15, 54 members were enrolled with 4 members pending enrollment.
5	Total capacity = 240. As of 2/27/15, 32 members were enrolled and 17 members are pending enrollment.
6	Total capacity = 240. As of 2/27/15, 29 members were enrolled and 6 members are pending enrollment.
7	Total capacity = 200. As of 2/27/15, 179 members were enrolled and 12 members are pending enrollment.
8	Total capacity remains at 240. As of 2/27/15, 220 members were enrolled and 20 members are pending enrollment.
9	Total capacity = 260. As of 2/27/15, 258 members were enrolled and 2 members are pending enrollment.

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 presentations among CSoC children with at least one ED visits is also reported. This measure does not capture enrollment into the CSoC program from ED's.

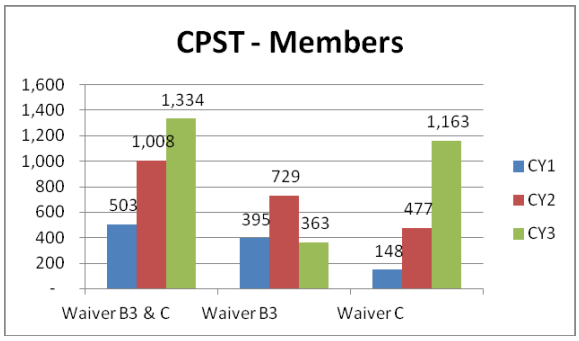
Time Period	ED PRESENTATIONS	UNIQUE CSoC MEMBERS	Total CSoC Population	% Of Members Utilizing	Average Presentations/K
CY2	265	185	1803	10.26%	146.98
CY3	306	193	2298	8.39%	133.16

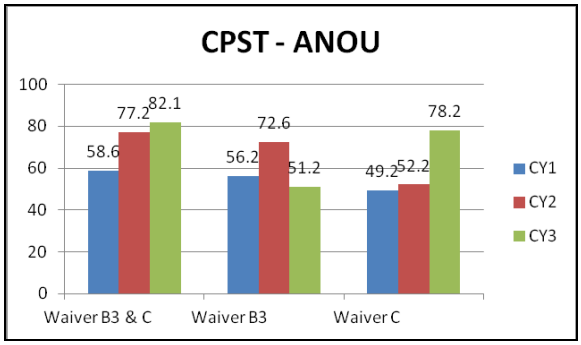
There was a 1.87% decrease in the percent of CSoC members utilizing EDs. With the maturity of the CSoC program and the improved Wraparound Facilitators skills, CSoC is having a positive impact on reducing the number of readmissions to higher levels of care for enrolled members.

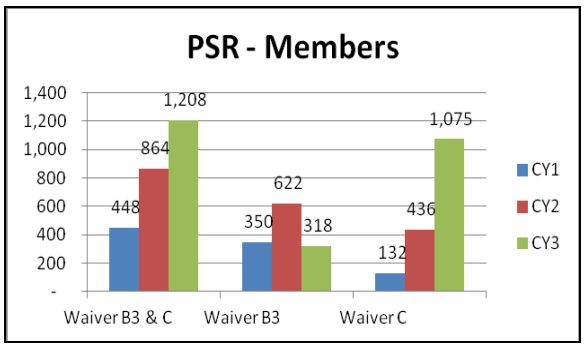
QA Report 3: Utilization of Community Resources/Report 11: Utilization of claims paid services

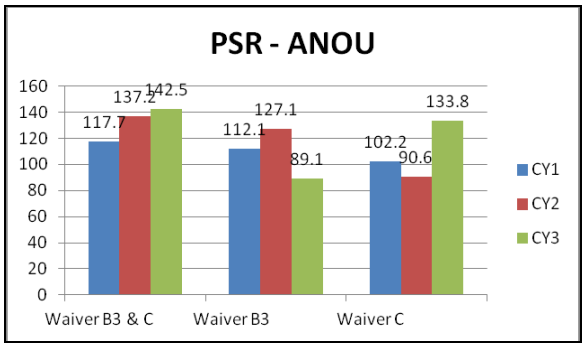
Data reported for the following services are claims-based and covers CY1, CY2, and CY3. Data are reported for the following home and community based services: Community Psychiatric Supportive Treatment (CPST), Psychosocial Rehabilitation (PSR), Parent Support & Training (PST), Youth Support & Training (YST), Independent Living/Skills Building (IL/SB), Short-Term Respite (STR), Crisis Stabilization (CS) and Crisis Intervention (CI). For each service, the number of members receiving that service and the Average Number of Units/mean (ANOU) are reflected in the charts below. The mean was calculated as the total number of community-based services billed divided by the total number of CSoC youth. Utilization of CPST and PSR continued to show steady, positive growth overtime. ILSB services showed slight increases in utilization. The most significant increases in utilization were demonstrated in both

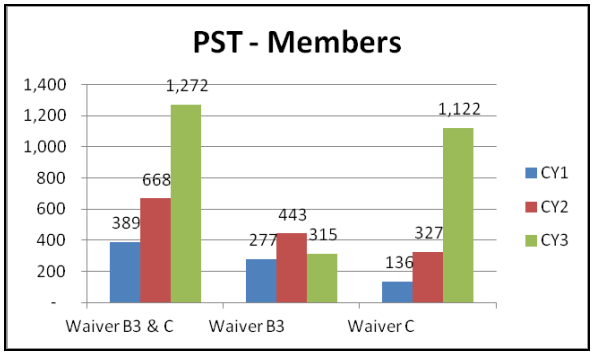
Parent Support and Youth support services in CY3. CS services were available in only one region of the state and thus the low utilization rates were noted. Because the data in both reports (#3 and #11) are reported on paid claims, the two metrics are included together on this part of Appendix D. Overall, there was a steady increase in home and community based service utilization by members enrolled in CSoC.

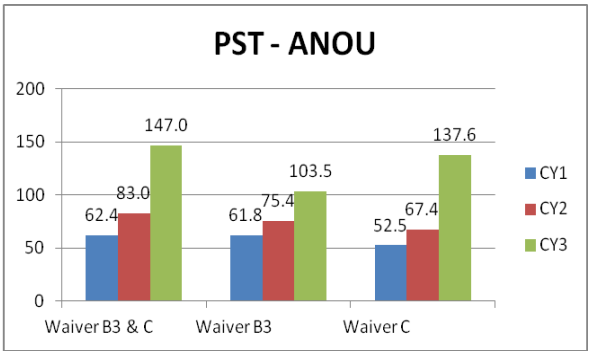


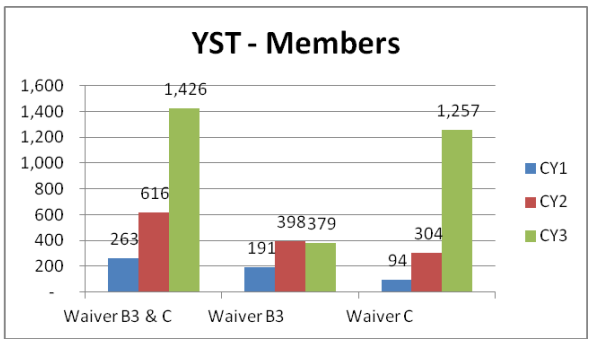


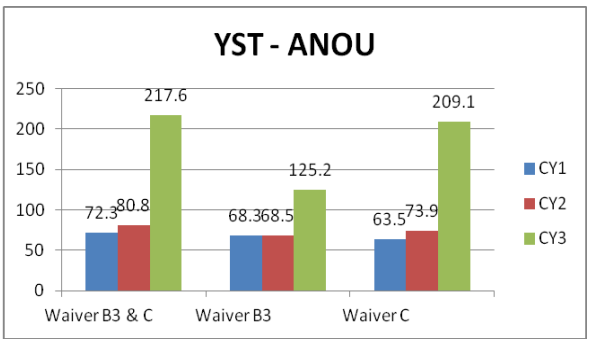









YST - Members
1,600
1,400
1,200
1,000
800
600
400
200
-
263
616
1,426
191
398
379
94
304
1,257
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3


YST - ANOU
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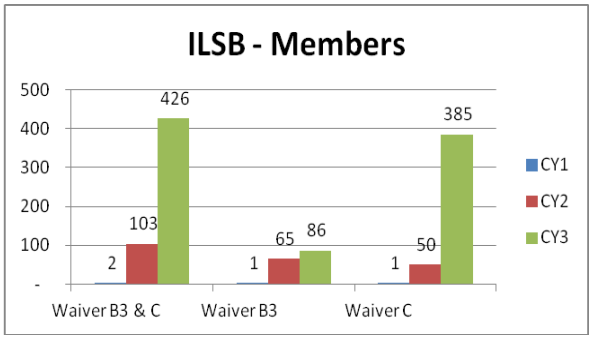
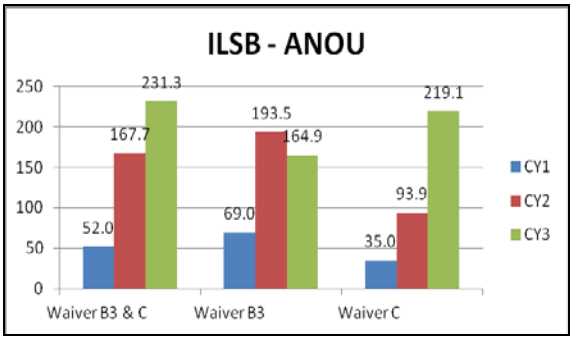
200
150
100
50
0
72.3
80.8
217.6
68.3
68.5
125.2
63.5
73.9
209.1
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3


ILSB - Members
500
400
300
200
100
-
2
103
426
1
65
86
1
50
385
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3


ILSB - ANOU
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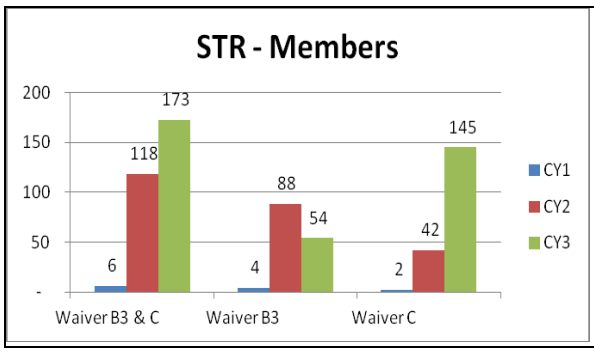
200
150
100
50
0
52.0
167.7
231.3
69.0
193.5
164.9
35.0
93.9
219.1
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3


STR - Members
200
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100
50
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6
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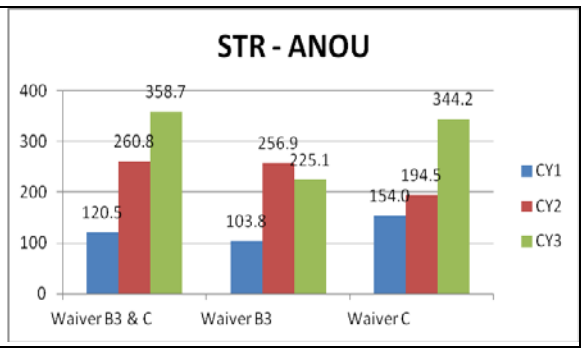
173
4
88
54
2
42
145
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3


STR - ANOU
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0
120.5
260.8
358.7
103.8
256.9
225.1
154.0
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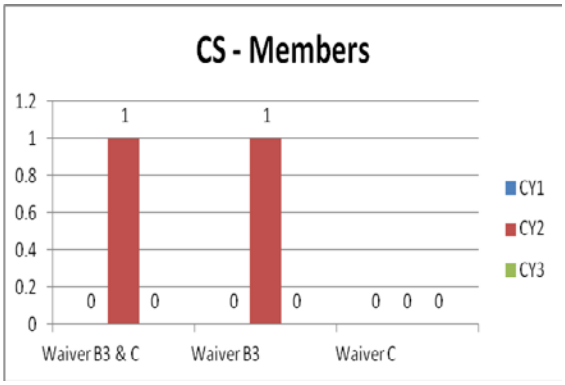
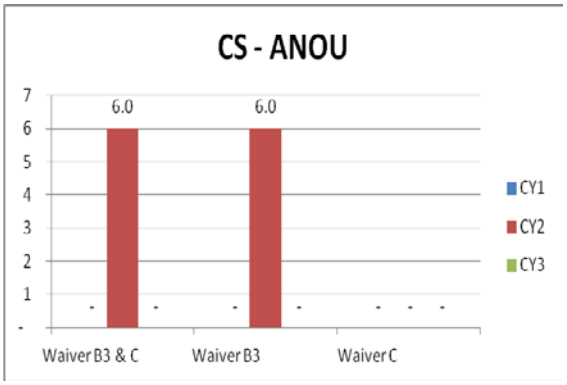
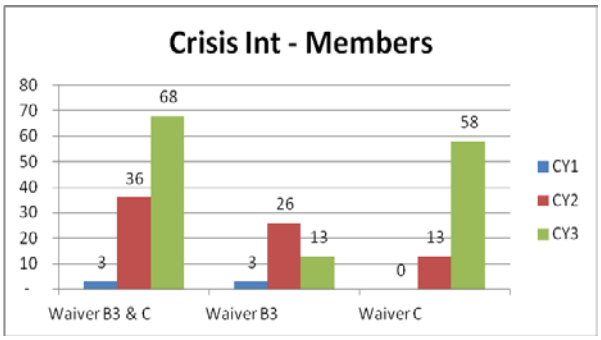
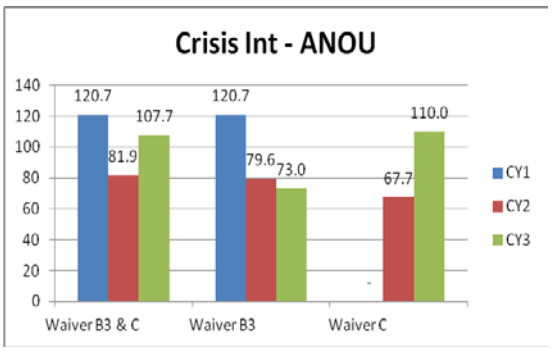
344.2
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3


CS - Members
1.2
1
0.8
0.6
0.4
0.2
0
0
1
0
0
1
0
0
0
0
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3


CS - ANOU
7
6
5
4
3
2
1
-
6.0
6.0
Waiver B3 & C
Waiver B3
Waiver C
CY1
CY2
CY3





QA Report 4: Utilization of WAA facilitated services

A. Failure to enroll within 10 days

- **CY2: 28.5%**
- **CY3: 4.9%**

During the implementation period, 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 affected the overall timeframes in which FOCs were signed and members enrolled. Interventions were implemented in CY2: 1) enforcement of Corrective Action Plans (CAP) when the 10 day time period was not met; and 2) Additional trainings for WAAs and Certified Providers about the new timeframes. During CY3, much improvement was seen by WAA staff and Certified Providers in engaging the youth and caregivers soon after the referral was received.

B. Refusal to sign FOC

- **CY2: 21.0%**
- **CY3: 2.3%**

During CY3, an 18.7% decrease in the number of members who refused to sign an FOC was demonstrated. Magellan developed a stronger Quality Management process with the WAAs that included: 1) CSoC QI/QM monthly technical support and training conference calls were started with the Wraparound agency QI Managers and Directors; 2) Additional 1:1 outreach calls with each Wraparound agency were held on an as needed basis for more specific regional QI issues and to find resolutions; 3) Enhancements were made to the CSoC QI Data Spreadsheet and Data Dictionary to aide WAAs in data collection and reporting efforts; 4) Report automation and the distribution of monthly WAA "Error" reports helped improve data submissions; 5) WAA QI Managers began holding their own internal trainings with wraparound facilitators on quality improvements and reporting on performance measures; and 6) Magellan continued to monitor the data collection and submission process and course corrected when deemed necessary.

C. ALOS

- **CY2: 269.2 days.**
- **CY3: 329.8 days.**

During CY3, there was a 22.5% increase in the average length of stay in the CSoC program.

WAA Region	Average Length of Stay	Median of Length of Stay	Mode of Length of Stay
All Regions	329.8	279	275

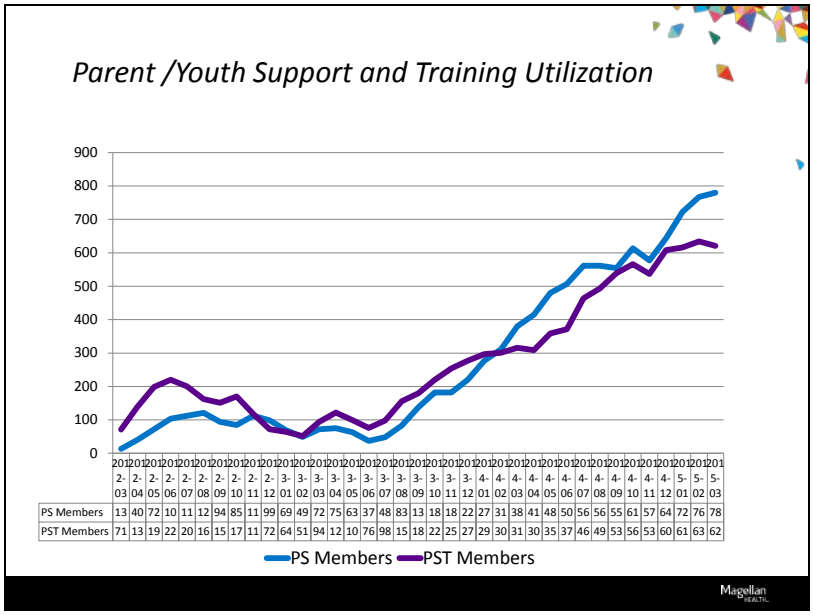
QA Report 5: Utilization of Peer Support Services

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.

CY2			
Procedure Description	**Number of Services**	**Number of Members**	**Mean**
YOUTH SUPPORT SERVICES	5353	623	8.6
PARENT SUPPORT SERVICES	6690	692	9.7

CY3			
Procedure Description	**Number of Services**	**Number of Members**	**Mean**
YOUTH SUPPORT SERVICES	28,187	1447	19.5
PARENT SUPPORT SERVICES	20,504	1353	15.2

YST and PST Utilization
(3/1/12-2/28/15)



	2012-03	2012-04	2012-05	2012-06	2012-07	2012-08	2012-09	2012-10	2012-11	2012-12	2013-01	2013-02	2013-03	2013-04	2013-05	2013-06	2013-07	2013-08	2013-09	2013-10	2013-11	2013-12	2014-01	2014-02	2014-03	2014-04	2014-05	2014-06	2014-07	2014-08	2014-09	2014-10	2014-11	2014-12	2015-01	2015-02	2015-03
PS Members	13	40	72	10	11	12	94	85	11	99	69	49	72	75	63	37	48	83	13	18	18	22	27	31	38	41	48	50	56	56	55	61	57	64	72	76	78
PST Members	71	13	19	22	20	16	15	17	11	72	64	51	94	12	10	76	98	15	18	22	25	27	29	30	31	30	35	37	46	49	53	56	53	60	61	63	62

During CY3, the SFSO increased Youth support service delivery and utilization by 10.9 average numbers of services; and Parent support service delivery and utilization by 5.5 average numbers of services. Magellan's Network Provider Relations Liaison continued to assist the SFSO on improving the claims submissions process and significant improvements were seen based on utilization data under the lead of SFSO Compliance Office/QI Manager. The SFSO continued to face challenges with high staff turnover rate in the early months of CY3, but implemented a more formalized orientation and overall training structure that had a positive impact on staff retention.

QA Report 6: Number of Peer Specialists Providing Services

Description	CY2	CY3
PEER (YOUTH) SUPPORT SERVICES	52	181
PARENT SUPPORT SERVICES	51	126
TOTAL	103	307

During CY3, the SFSO increased their Youth Support Specialists by 129 and Parent Support Specialists by 75. Magellan continued to monitor the SFSO interventions list on the Corrective Action Plan (CAP) for several quarters, which included additional staff member training requirements on: "Coaching on Communication Skills," "Management Boundaries and Barriers," "Conducting Effective Trainings, Understanding and Communicating the Ekhaya FSO policies and procedures," and "Community Partner relationship building." Magellan's Chief Medical officer remained involved in monitoring the SFSO CAP activities. No additional quality of care or adverse incident issues were reported in the last quarter of CY3.

SFSO Executive Director, Chief Compliance Office and Quality Manager attended the Magellan 2nd Annual CSoC QI/QM and 1915c HCBS Waiver Training held 4/1/15. MY LIFE groups facilitated by Magellan's Resiliency and Recovery Family Lead were held monthly in two regions: 2 and 8.

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

- **CY2: 2.94 plans**
- **CY3: 9.19 plans**

There was an increase of 6.25 average number of wraparound plans developed per youth from CY2 to CY3. Interventions implemented during this year included: 1) 2nd Annual CSoC QI/QM and 1915c waiver training held 4/1/15; 2) a monthly conference call with WAA QI Managers and Directors specifically on improving data collection and reporting efforts; 3) Debriefings after onsite waiver audits that provided immediate feedback re: POC and their development; and 4) Enhancements were made to the CSoC QI/QM Data Spreadsheet that allowed for closer monitoring of data submissions.

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

Summary	CY2	CY3
Members who were screened for Eligibility	2,366	2,127
Members who were deemed initially eligible	2,210	1,994
Percent	93.4%	93.7%

On 11/20/14, CSoC Phase II Go-Live began and it allowed for an additional 1,200 positions to open for the CSoC program statewide. Members already being served by Magellan's Resiliency Care Management (RCM) team were contacted and given the opportunity to transfer to a CSoC Wraparound agency in their region. Many members and families chose to make that transition. A decline in the number of referrals sent to RCM began since the CSoC Expansion Phase II Go-Live date. This trend is anticipated to continue until all 2,400 positions in CSoC are filled. Magellan's "Enrollment Management" process continued to track and monitor the number of incoming referrals, meet the supply and demands unique to each CSoC region and WAA staff capacities while providing each member with the appropriate care coordination. Wraparound agencies have also continued their efforts to hire and train new staff to meet the referral demands of their respective regions.

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

- **CY2: 100% of member records sampled had crisis plans developed**
- **CY3: 100% of member records sampled had crisis plans developed**

During CY3, Magellan enhanced the capabilities of capturing whether a member's crisis plan had actually been "Implemented" or not by revising the onsite waiver audit tool that is conducted quarterly. The revised audit tool included a new line item with the language: "Member experienced a crisis and a crisis plan was implemented as part of individual service plan;" however, crisis plan implementation remains a difficult element to capture in data since each CSoC enrolled member's crisis plan is very individualized and based on those crisis' the member and/or caregiver report to the Child and Family Team and the Wraparound Facilitator.

QA Report 10: Inpatient Hospitalization Readmission Rate

- **CY2: 22.00%**

Discharge Days	Discharges	Discharge ALOS	Admits	Readmits	Readmit Rate
3022	266	7.77	268	58	22.00%

- **CY3: 19.49%**

Discharge Days	Discharges	Discharge ALOS	Admits	Readmits	Readmit Rate
3393	266	8.08	272	53	19.49%

The metric is defined as the number of re-admitted divided by all CSoC youth with at least one in-patient admission. By the end of CY3, although the CSoC program population served increased to 4,351 members, the number of inpatient hospitalization re-admissions declined and the inpatient hospitalization readmission rate decreased by 2.51%.

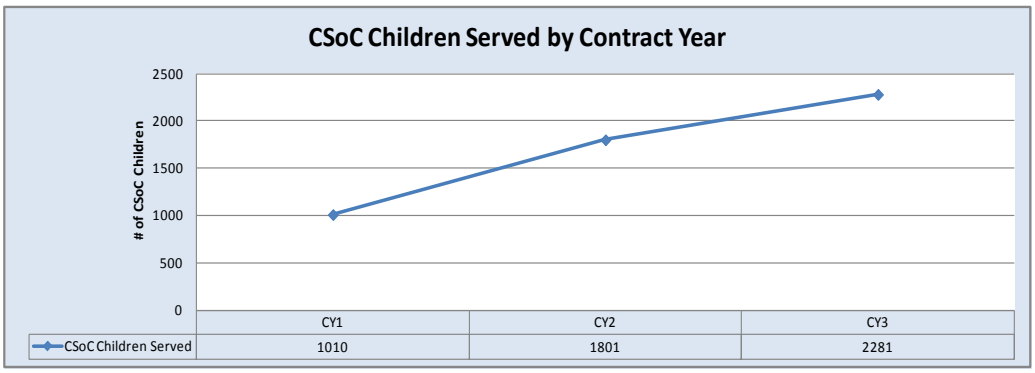
QA Report 11: Utilization of claims paid services

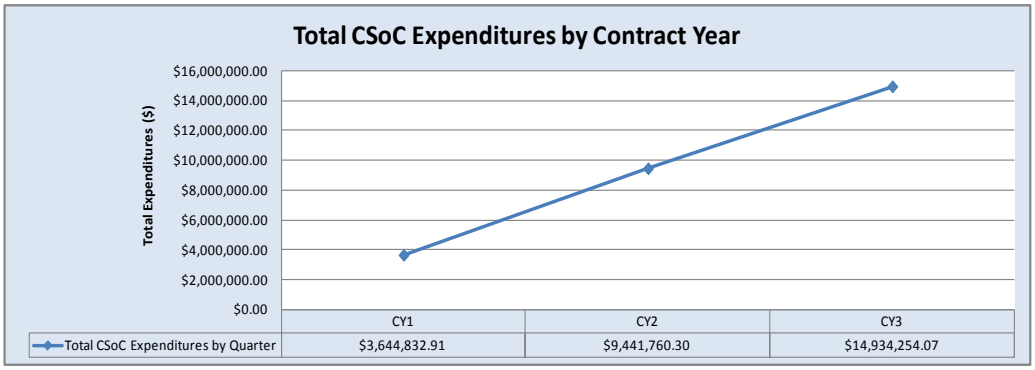
See report 3.

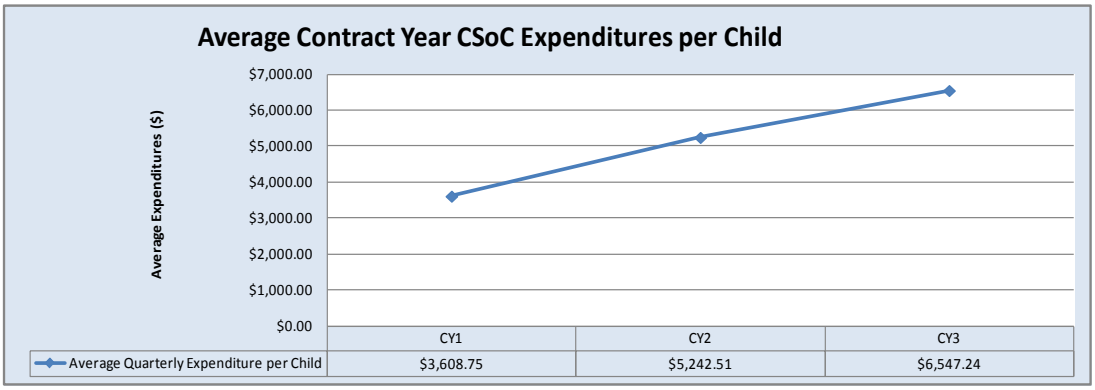
QA Report 12: Behavioral health cost per person served, per month

The metric is defined as the mean expenditure per month for all CSoC children divided by the total number of CSoC children. The charts and graphs outline the details of this metric and show increases in expenditures from CY1- CY3 as the number of members enrolled increased over the same three year period, ending with 4,351 members served by the end of CY3 with an average expenditure per member at $6,547.24. 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.

Metric	CY1	CY2	CY3
CSoC Children Served	1010	1801	2281
Total CSoC Expenditures by Quarter	$3,644,832.91	$9,441,760.30	$ 14,934,254.07
Average Quarterly Expenditure per Child	$3,608.75	$5,242.51	$6,547.24







CSoC Expenditure

Report ID : LCNS0004M

All CSoC		
Children	**Total Expenditure**	**Average Expenditure Per Child**
2281	$14,934,254.07	$6,547.24

Non Medicaid			
Level of Care	**Children**	**Total Expenditure**	**Average Expenditure Per Child**
Crisis Stabilization	0	$0.00	$0.00
Inpatient	0	$0.00	$0.00

Intensive Outpatient	0	$0.00	$0.00
Other	0	$0.00	$0.00
Outpatient	0	$0.00	$0.00
Parent Support	0	$0.00	$0.00
Partial	0	$0.00	$0.00
Peer Support	0	$0.00	$0.00
Residential	0	$0.00	$0.00
Short Term Respite	0	$0.00	$0.00
Skill Building	0	$0.00	$0.00
TOTAL	0	$0.00	$0.00

Medicaid			
Level of Care	**Children**	**Total Expenditure**	**Average Expenditure Per Child**
Crisis Stabilization	0	$0.00	$0.00
Inpatient	440	$2,063,351.67	$4,689.44
Intensive Outpatient	13	$20,866.77	$1,605.14
Other	0	$0.00	$0.00
Outpatient	2139	$6,014,973.69	$2,812.05
Parent Support	1216	$1,509,179.80	$1,241.10
Partial	0	$0.00	$0.00
Peer Support	1325	$2,506,968.80	$1,892.05
Residential	182	$1,860,774.84	$10,224.04
Short Term Respite	174	$248,574.30	$1,428.59
Skill Building	395	$709,564.20	$1,796.37
TOTAL	2281	$14,934,254.07	$6,547.24

School Performance Measures (Reports 13, 14, 15)

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 efforts continue to provide an opportunity for growth.

QA Report 13: School Attendance

CY3 - School Attendance/ Missed Days				
REPORTING PERIOD	**1**	**2**	**3**	**4**
3/1/2014-2/28/2015	3.53	2.15	7.29	7.64

Discussion and action plan is found in Report 15.

QA Report 14: Conduct- Suspensions/Expulsions

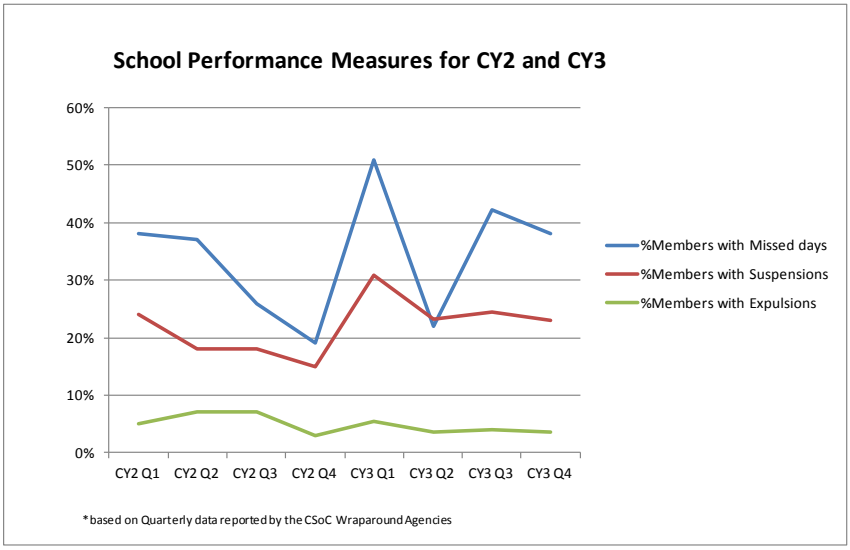
This metric is defined as the percentage of CSoC youth that have been suspended or expelled and defined as the number suspended + expelled (defined by DOE) divided by all current CSoC children.

CY3 - Suspensions				
REPORTING PERIOD	**1**	**2**	**3**	**4**

3/1/2014-2/28/2015	30.8%	23.3%	24.4%	23.10%

CY3 - Expulsions				
REPORTING PERIOD	**1**	**2**	**3**	**4**
3/1/2014-2/28/2015	5.4%	3.6%	4.0%	3.5%

The CSoC program expanded into four additional regions on 11/20/14. The school performance data for those new regions are included in the 4th reporting period only. As the four new regions joined CSoC, less errors in the initial reporting was seen contrary to earlier implementation in years 1 and 2; thus, it seemed that the "lessons learned" from the original five Wraparound agencies and advanced training on these PMs by Magellan helped to minimize reporting errors and maintain the high levels of report counts that had been coming in. Also, CSoC QI/QM monthly technical support and training calls were conducted with Wraparound agency QI Managers and Directors and school PM data collection and reporting topics were frequently discussed. 1:1 outreach calls with each Wraparound agency continued to be held on an as needed basis with QI Managers to address more specific regional QI issues and find resolutions. Report automation and the distribution of monthly WAA "Error" reports continued to show improvements in school performance data submissions overall. The graph below combines all school PMs and displays them over the CY2 and CY3 reporting periods. As previously noted, "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."



QA Report # 15 School Performance (GPA's)

CY3 - GPA				
REPORTING PERIOD	**1**	**2**	**3**	**4**

3/1/2014-2/28/2015	2.28	1.8	2.26	2.22

The same challenges remained this contract year when trying to accurately capture each CSoC member's school performance reported using grade point averages (GPAs) since they are reported differently in each school district and with varying grading scales. Alternative schools, private schools, homeschooled members and those in GED programs present additional challenges when trying to capture accurate GPAs as well.

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

- Magellan moved to automated reports on school performance measures; thus, allowing for a more detailed presentation of the outcomes data submitted.
- Monthly CSoC Quality Improvement/Quality Management conference calls started in 2014 with WAA QI Managers and Directors with the goal of improving data collection and submission processes and course correct as needed. New QI staff joined the conference calls after 11/20/14 Phase II Go-Live date and were able to establish data integrity practices with their respective staff from implementation.
- Magellan DOE Liaison joined forces with WAA Directors and OBH CSoC teams' DOE Liaison and continued outreach efforts to school districts across all 9 CSoC regions statewide and in community forums explaining the need for collaboration between educational entities and the Wraparound agencies of member data with the informed consent of the member and/or guardian.

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

- **CY2:**

Population	OOH Placements - CSOC	OOH Members - CSOC
All CSoC	418	275
1915c	175	118
1915b3	241	175
no waiver	2	2

- **CY3:**

Population	OOH Placements - CSOC	OOH Members - CSOC
All CSoC	506	310
1915c	380	234
1915b3	113	91
no waiver	13	13

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 operational team members continued to monitor providers to ensure that they

were implementing plans of care that met the specific service delivery needs of these children in order to reduce total out-of-home placements.

QA Report 17: Utilization of Natural Supports

Data do not take into account how often an individual child utilized his/her natural supports. As part of the Wraparound philosophy, the child and family are able to choose what natural supports they would prefer to be part of the child and family team (CFT); therefore, this number can vary during any given reporting period. There are no claims encounters to track for the "utilization" of natural supports since this is not a billable service.

Natural and Informal Support Utilization		
	CY2	**CY3**
Total # of CSoC children/youth	1034	2545
# of children that have utilized natural supports	777	2476
Percent of members utilizing natural supports	75%	97%

During CY2, collaboration between OBH and Magellan CSoC teams and the University of Maryland Wraparound Trainers resulted in more succinct definitions of "Natural" vs. "Informal" supports and the revision of the CSoC QI Data Spreadsheet to reflect those definitions was created. Magellan facilitated technical assistance conference calls with all WAA QI Managers and Directors to review and explain the data collection spreadsheet and the Data Dictionary that was added. During onsite meetings at the WAAs, continued training was conducted re: what constitutes a "Natural" or "Informal" support and how to record utilization of these supports on the data collection spreadsheets. A uniform Plan of Care was distributed to the WAAs that required enhanced documentation and tracking of the type and frequency of natural and informal supports for each member served.

During CY3, Magellan's CSoC Operations team continued to monitor the inclusion of natural and informal supports on member's POCs to ensure increased utilization. Continued improvements with data submission were observed, evidenced by: 1) higher rates of overall counts submitted in the appropriate spreadsheet fields and, 2) less confusion around terminology or their meanings. Magellan facilitated 1:1 outreach calls to WAA QI Managers and monthly CSoC QI/QM calls that provided ongoing technical support and guidance for data collection issues. Enhanced report automation improved reporting capabilities as well.