
MAGELLAN HEALTH SERVICES
BEHAVIORAL HEALTH STRATEGIC BUSINESS UNIT

# QUALITY IMPROVEMENT – UTILIZATION MANAGEMENT PROGRAM EVALUATION

FOR

LOUISIANA CARE MANAGEMENT CENTER

3-1-2012 - 2-28-2013

TABLE OF CONTENTS

**Executive Summary**

The Magellan of Louisiana Care Management Center conducts an annual evaluation of its Quality Improvement and Utilization Management Programs to assess program outcomes, review their effectiveness, determine progress toward program goals, evaluate the deployment of resources, document and trend input from advisory groups (including consumers, family members and other stakeholders), and identify opportunities for improvement in the provision of evidence-based, high-quality care and service to members. The evaluation covers a fully integrated quality program, including recovery/resiliency-focused clinical and medical integration programs. This report summarizes the evaluation findings from the Louisiana Care Management Center data from 3-1-12 through 2-28-13. Since the CMC began providing services on 3-1-12, there are no updates on prior years.

**Key Accomplishments**

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

1. Managed services for 142,923 Louisiana citizens between March 1, 2012 and February 28, 2013

2. Developed the managed care infrastructure to provide needed services to the Louisiana Medicaid population including the 1915 (c) and 1915 (b) waiver services, and the 1915 (i) State plan amendment.

   Departments developed include:

   a. Member Services - Composed of 27 staff, the Member Services Department is responsible for answering incoming calls from providers and members and determining the needed steps to address questions, issues, and problems. Member services received 119,020 phone calls in the first contract year and answered 117,059 of those calls. Member Services met the performance guarantee goals for percentage of abandoned calls ($\leq$ 5%) and average speed of answer (ASA) ($\leq$ 30 seconds) in the first year, with an annual average speed of answer of 7.4 seconds and a call abandonment rate of 1.4%. Magellan of Louisiana also distributed 350,000 fat bookmarks, an educational piece informing members of Magellan's presence in Louisiana.

   b. Care Management Services (Utilization Management & Recovery Care Management) – Managed all clinical cases, authorizing and reauthorizing medically necessary services, and worked collaboratively with Physician Advisors to improve clinical outcomes.

   c. Network Management – Developed and managed a provider network of over 625 facilities, 215 groups, and 2,049 certified providers across the state who are qualified to provide a wide variety of services, including inpatient psychiatric care, inpatient residential substance abuse care, Home & Community-based

Services (HCBS), Assertive Community Treatment (ACT), CSoC Services (respite care, crisis management, youth support and training, parent support and training, and independent living skills, Wraparound (WAA), Functional Family Therapy, Multi-Systemic Therapy, Homebuilders, therapy services (Psychiatrists, Psychologists, Social Workers, Licenses Professional Counselors, Licensed Addiction Counselors), and a variety of outpatient community-based services. Network development met established geographic access goals for over 96.9% of the membership with an average distance to provider of 10.6 miles.

d. Quality Improvement (QI) – This team supported coordination of quality improvement initiatives across the CMC, including:
    i. Development of a comprehensive quality committee/subcommittee structure to oversee the quality and effectiveness of services delivered to Louisiana Medicaid members.
    ii. Provider monitoring through Treatment Record Reviews and follow-up
    iii. Oversight and coordination of review and investigation of Quality of Care concerns and Adverse Events
    iv. Compilation and monthly reporting of required Performance Guarantee metrics
    v. Development of report structure and report analysis for required Waiver measures
    vi. Development and promotion of the provider dashboard
    vii. Presentation, discussion, and approval of required policies and procedures through the QIC
    viii. Coordination of activities to support URAC accreditation process
    ix. Development of formal Performance Improvement Projects

    QI identified and addressed six Performance Improvement projects, including coordination of care with Primary Care Physicians, reducing average speed of answer and phone call abandonment rates, and increasing the reporting of Adverse Incidents. QI further provided data analysis and quality monitoring for reports developed across the CMC, including monthly CSoC and Performance Guarantee Reports. In addition, QI developed reports for a variety of external stakeholders, including OBH, the State legislature and the CSoC Governance Board. By the end of the contract year, QI had reviewed 52 facilities (including 39 inpatient facilities, six outpatient facilities, six residential substance abuse facilities, and one Wraparound Agency). An opportunity for improvement includes increasing the review focus of waiver-specific services.

3. Developed in-person and online educational training to ensure Magellan staff members are familiar with policies and procedures regarding privacy, fire safety, ethical issues, fraud, waste & abuse, cultural sensitivity, CPT code changes, Risk Management, CSoC initiative, Six Sigma principles, patient safety issues, and adverse incidents. In addition, multiple targeted trainings were presented on topics specific to the Louisiana Medicaid population (see training report within Evaluation).

4. Initiated an innovative intervention toward improving communication and access to care by partnering with a cell phone company to distribute free cell phones to a segment of the Louisiana Medicaid adult population. Program fully developed for go live in April of 2013.

5. Active collaboration with local Governance Board composed of Magellan leadership, providers, and community stakeholders from around the state representing various constituencies; Board has responsibility for providing direction and recommendations to improve Care Management Center activities.

6. Established a Regional Network Credentialing Committee (RNCC) with responsibility to oversee the suitability and quality of providers serving our members. The RNCC provides oversight of credentialing and re-credentialing activities as well as providing a component of local peer review of regionally assigned providers. The RNCC has the authority to take appropriate actions regarding enrollment status in the network.

7. Developed and implemented a comprehensive Medical Action Plan (MAP). The MAP documents action and progress on key program activities, including tracking readmission rates and average lengths of stay (ALOS) for children and adults by level of care. The Magellan Chief Medical Officer meets regularly with the Bayou Health plans to promote integration of care and develop strategies for managing members with co morbidities.

8. Developed and implemented a Recovery Case Management program (RCM) as well as a "birth outcomes initiative program" to encourage referrals from OB/GYN's.

9. Implemented interventions to increase coordination of care with mental health providers upon discharge from inpatient facilities.

10. Initiated activities to develop a crisis network.

11. Developed and implemented an appeals tracking system and an independent audit process to ensure timeliness of completion and integrity of documentation related to appeals reviews.

12. Deployed a complaint resolution tracking system to ensure capture and timely response to member and provider complaints. System facilitates trending of complaints to identify opportunities for improvement.

13. Developed and implemented a long-term plan for improving provider cultural awareness and competency, as well as development of a method for assessing provider cultural competency that determines what cultural competency workshops might best serve the provider network.

14. Exceeded the overall provider satisfaction threshold goal by five percentage points with an aggregate result of 80.2%

15. Developed and implemented a Coordinated System of Care Program (CSoC) for children who are considered to be at risk for out of home placement. The CSoC program network includes five participating Wraparound Agency (WAA) providers and one statewide Family Service Organization (FSO) that manage the provision of services. For this initial contract year, the CSoC program made 2,016 referrals of children to WAAs based on Comprehensive CANS screening. The total enrollment in WAAs during the year was 1,295. At the end of the contract year, there were 723 CSoC children enrolled with the WAAs.

16. Presented over 100 trainings to the LA CMC staff during the contract year; topics included practice guidelines, security/ethics, cultural awareness, and accreditation. (Please refer to Appendix D for a list of trainings)

**Prioritized Opportunities for Improvement for 2013**

Prioritized opportunities for improvement identified as a result of this evaluation include:

- Develop a strategy to address the needs of high-utilizing members
- Reduce inpatient readmission rates
- Continue activities to develop a crisis services network
- Improve the development and capture of outcomes measures based on the use of assessment/outcome tools
- Improve ambulatory follow-up rates for members with a mental health diagnosis who are discharged from an acute care facility
- Improve information exchange between Magellan and the Bayou Health plans
- Achieve Full URAC accreditation status
- Continue PIP to promote improvement for member access to care

**Program Focus and Prioritized Objectives for 2013**

Based on a review of:

- Progress towards 2012 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,
- OBH feedback, contractual and waiver requirements
- Consumer, family member and stakeholder input,

the following primary areas of focus have been identified as prioritized objectives for the Louisiana CMC:

- Develop standardized report formats and routine reporting as required for all 1915(b) and 1915(c) waiver, and 1915(i) State plan amendment requirements
- Shift utilization from higher levels of care to increased home and community-based treatment programs
- Reduce inpatient readmission rates
- Increase ambulatory follow-up rates after discharge from inpatient settings
- Automate CANS assessments to promote trending and analysis, and facilitate measurement of outcomes
- Continue to improve consistent application and inter-reliability of clinical decision-making by physician advisors, care managers, and treatment record reviewers (through established inter-rater reliability processes)
- Expand the availability of 1915c waiver services to the eligible population
- Improve outreach to and communication with family members and stakeholders
- Finalize and release enhancements to the provider profiling dashboard
- Demonstrate fidelity of empirically supported treatment programs
- Develop performance improvement plans to address opportunities identified based on provider and member satisfaction survey results
- Address the strategic shift in youth bed composition across the state (PRTF, TGH)
- Increase visibility and viability of MYLIFE in Louisiana
- Increase number of children served in CSoC program and document improvement (through change in CANS, reduced out of home placement, fewer crisis services needed, improved educational performance and behavior)
- Continue expansion of the cell phone pilot project with the Louisiana Medicaid adult population
- Continue development of the Tiered Care Management Program that enhances case management reporting

**Acknowledgment and Approval**

The 2013 Quality Improvement and Utilization Management Program Evaluation was prepared by the Louisiana CMC and reviewed and approved by the Quality Improvement Committee during its meeting on July 25, 2013, as indicated by the signature(s) below:

_____ _____

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

## Quality Improvement and UM/CM Program Evaluation

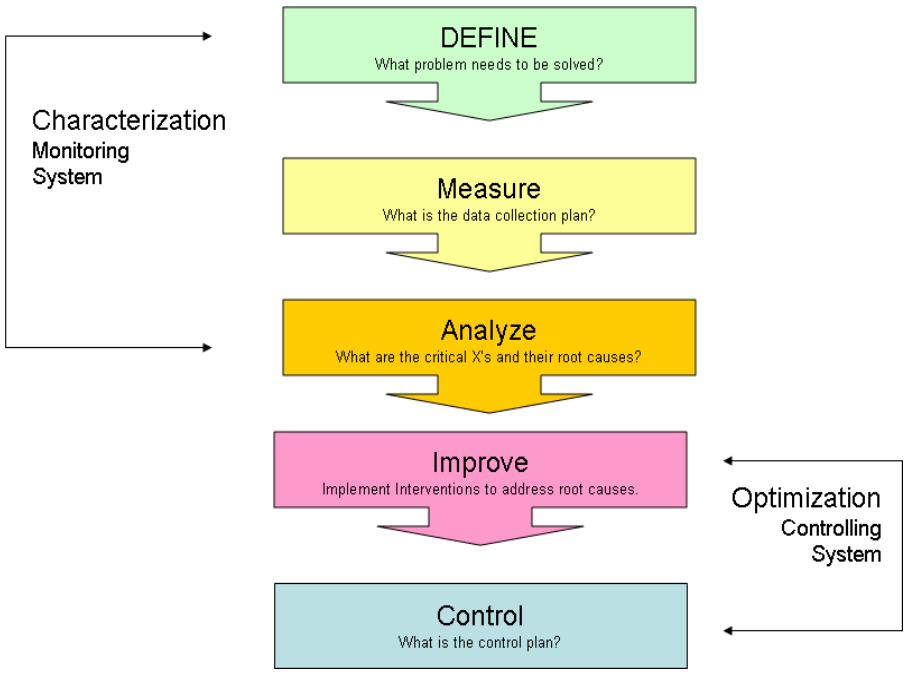
## I. Overview

The Magellan Health Services Louisiana Care Management Center (CMC) manages the behavioral health, recovery and resiliency, and substance abuse services delivered by providers from several disciplines in a variety of settings. The Louisiana CMC manages the services provided to the Medicaid population of Louisiana, as well as members who receive services directly through the Office of Behavioral Health (OBH) clinics.

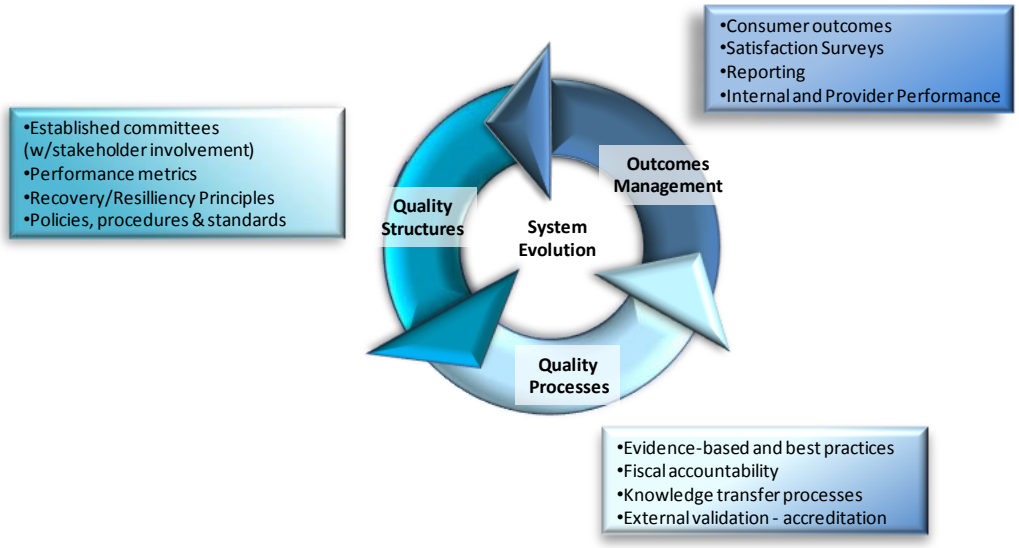
The scope of the Quality Improvement (QI) program includes the objective and systematic monitoring of the quality of behavioral health and related recovery and resiliency services provided to the members of Magellan's customer organizations. The Louisiana CMC QI Program is the direct responsibility of the Louisiana CMC CEO, Craig Coenson, MD. The QI program is managed by Seth Kunen, PhD, PsyD, Quality Management Administrator, who is supported by regional and corporate staff. Local oversight of the QI program is provided by the Louisiana Quality Improvement Committee (QIC). Corporate oversight of the QI program occurs through the Magellan corporate committee structure.

**Quality Processes at the Louisiana Care Management Center**

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



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




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

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

### A. Louisiana Population and Magellan Membership Demographics

According to the 2012 United States Census, there are 4.6 million Louisiana citizens. Females represent 51.1% and males represent 48.9% of the Louisiana population. Caucasians represent 63.8% and African Americans represent 32.4% of the Louisiana population. The Louisiana population is composed of relatively few members of other races and ethnicities. For example, only 1.6% of the population is of Asian descent, 0.1% is Native Hawaiian/Other Pacific Islanders, and 4.4% is of Hispanic or Latino origin. Approximately 7% of the population is under age five, 24% of the population is under age 18, 24.5% of the population is aged 19 to 64, and 51% of the population is 65 and over. The 1.3 million Louisiana citizens, who are Medicaid members, represent about 28% of the Louisiana state population. In 2010, the number of Medicaid members whose ages were 20 and under was 679,182 (LA DHH State Fiscal Year 2009/2010 Medicaid Annual Report). Approximately 16.3% of the Louisiana population lives at or below 100% poverty level compared to 13.8% for the United States as a whole.

An analysis of authorized services from Magellan's internal clinical management data system produced the following demographic profile of the Magellan membership. Females represented 56% (about 5% higher rate than in the Louisiana population at large) and males represented 43.7% of the members served. As can be seen in the race table below, African Americans represented 50.8% of the membership receiving services (among those with known race), while Caucasians represented 47.2% of the membership receiving services. Since African Americans represent 32% of the Louisiana state population but almost 51% of the Magellan membership, it is clear that African Americans experience fewer barriers to accessing care. Together, African Americans and Caucasians represented 98% of the membership served by Magellan of Louisiana. Very few Native Americans (n = 96), Hawaiian/Pacific Islanders, Alaskan natives (n = 6) or persons of Hispanic or Latino origin (n = 841) sought services from Magellan, which is not surprising, given their low percentages in the Louisiana state population. The following tables present the race and ethnicity distribution among Magellan members. The following table illustrates that of members with known race, Caucasians and African Americans represent 98% of the Magellan members.

| Race | Frequency | Percent |
|---|---|---|
| **Alaskan Native** | 6 | .0 |
| **American Indian** | 96 | .2 |
| **Asian** | 100 | .2 |
| **African-American** | 20,396 | 50.8 |
| **HI/Pacific Islander** | 75 | .2 |
| **Other Ethnicity** | 402 | 1.0 |
| **Other/Single Race** | 125 | .3 |
| **Caucasian** | 18,937 | 47.2 |
| **Total** | 40,137 | 100.0 |
| **Unknown** | 19,110 | |
| **TOTAL** | 59,247 | |

The table below illustrates that non-Hispanic/non-Latinos represent nearly 98% of the Magellan membership. It should be noted that many members do not report ethnicity, so findings are based on those that have provided this information.

| Ethnicity | Frequency | Percent |
|---|---|---|
| **Central or South American** | 321 | .9 |
| **Cuban** | 9 | .0 |
| **Hispanic or Latin of unknown origin** | 110 | .3 |
| **Hispanic/Latino** | 379 | 1.0 |

| Ethnicity | Frequency | Percent |
|---|---|---|
| **Mexican or Mexican American** | 36 | .1 |
| **Non-Hispanic or Non-Latino** | 36,690 | 97.7 |
| **Puerto Rican** | 26 | .1 |
| **Total** | 37,571 | 100.0 |

**B. Cultural Competency Assessment**

Magellan maintains a strong focus on continuous quality improvement. Each CMC department manager or supervisor is accountable for the success of the Program through integration of the principles of cultural competency in all aspects of organizational planning and working to assure cultural competence at each level within the system. The CMC coordinates input from a variety of stakeholders, including administrative staff, front line employees, consumers and community organizations for the development and operation of the Cultural Competency Program.

The QI Program includes indicators to assure equal delivery for all services described in the program description. Indicators include, but are not limited to:

- Complaints and compliments, including monitoring of complaints for issues that are potentially related to culturally insensitive practices.

- 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.

Member satisfaction surveys actively solicit member satisfaction and concerns about linguistic and communication access. Annual geographic access studies ensure that contracted practitioners and facilities are available in the communities in which members reside. Appointment availability and customer service telephone response time is monitored for timely responsiveness to member needs. In addition, all policies and procedures related to cultural competency, related program correspondence and quality improvement documents - including this program description – are subject to regular review through the Quality Improvement Program and structures.

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

Guiding Principles for the Magellan Cultural Competency Program include:

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

The goals of the Magellan Cultural Competency Program include:

- Enabling staff and affiliated providers to deliver culturally competent care in an effective, understandable, and respectful manner that is compatible with the members' cultural health beliefs, practices, and preferred language. Services are designed to affirm and respect the worth of the individual and the individual's dignity.
- Providing cultural competency trainings to staff. The Achieve website has several cultural competency trainings and the Director of the Race and Equity Committee regularly presents on cultural competency issues.
- Recruiting and retaining a diverse staff and leadership that is representative of the membership we serve. Our local CMC staff demographics generally mirrors our membership.
- Offering language assistance to members whose primary language is not English and ensuring that policies and procedures are written in the languages of commonly encountered members. The entire LA CMC website and the member handbook are available in Spanish and Vietnamese, as are Notice of Action letters sent to members.
- Creating a cultural competency plan that is based on the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).
- Ensuring that front line staff who have direct contact with members display cultural sensitivity in their interactions. The quality of services provided is assessed through an automated phone system that permits managers to review and assess the phone service provided by member services and care managers (see data quality policy in Appendix E).
- Ensuring that the facilities in the Magellan provider network meet the Americans with Disability Act access requirements.
- Providing a telephone prompt for all members with Spanish and Vietnamese language preferences that a language translation service is available.

The Magellan cultural competency program initiatives and presentations completed during the year include:

- Demographic analyses that revealed the need for telephonic prompts in Spanish and Vietnamese. A search for contractors to implement these language prompts began in January of 2013 and a contractor was hired with prompts implemented on May 16, 2013.
- Development of the Louisiana member website with materials and information available in English, Spanish, and Vietnamese.
- A presentation to the CSoC staff on cultural communication.
- Presentations to DHH-OBH statewide Louisiana Spirit teams on "Cultural Competency 101."
- Publication of bi-monthly cultural competency articles for Magellan Behavioral Health in Louisiana "Partnership Providers News" (newsletter).
- Publication of articles on cultural sensitivity on Magellan's Magnet web page.
- A presentation to the NAMI Louisiana Statewide Conference – Covington, LA. - April 5, 2013 on "Culturally Competent Care from a Latino Perspective."
- A presentation to Annual United States 37th Psychiatric Rehabilitation Association (USPRA) Conference – Minneapolis, MN – May 22, 2012 entitled "Am I being Culturally Competent or Politically Correct?"
- Development on the Corporate ACHIEVE website of four courses on cultural diversity.
- Incorporation of the National Standards on Culturally & Linguistically Appropriate Services (CLAS Standards) into the cultural competency program.
- Contracting with Global Interpreting Services and Pacific Interpreting Services to provide translation services for members.
- Development of a multicultural competency self-assessment tool for providers. This self-assessment is expected to facilitate identification of needs and provision of workshops to address provider cultural competency needs. This cultural self-competency assessment instrument is presented in Appendix F.

The cultural competency training program used by Magellan follows the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) as outlined by the US DHHS Office of Minority Health, March 2001. Approximately 125 staff took 184 Cultural Competency trainings on the Magellan Achieve Website between March 1, 2012 and March of 2013. This curriculum is based on sound adult learning principles and includes pre and post training assessments. It is conducted by appropriately qualified individuals and it is tailored to the functions of trainees and needs of populations served. This cultural competency training curriculum on the Achieve learning website includes:

- Magellan expectations and policies
- CLAS Standards (provided at the CMC)
- Introduction to cultural terminology
- Cultural sensitivity
- Cultural competence skills

**C. Diagnostic Prevalence**

The Louisiana CMC provides services to a population with a wide range of needs. The following table presents the five most frequently occurring diagnoses of members who received

authorizations for services. The top five psychiatric diagnoses from March 1, 2012 to Feb 28, 2013 (excluding deferred diagnoses) are presented in the table below. Mood disorders are the most common psychiatric diagnoses across all levels of care, including inpatient hospitalization, CSoC program, and Home and Community-based Services, while Disruptive Behavior Disorders are the most common psychiatric disorder seen among children.

| Diagnosis | Total | % of Total |
|---|---|---|
| **All Mood Disorders (Including Bipolar Disorder)** | 30,087 | 34.9% |
| **Disruptive Behavior Disorders (ADHD, ODD, Conduct Disorder)** | 21,325 | 24.7% |
| **Substance Use Disorders** | 14,919 | 17.3% |
| **Psychotic Disorders** | 12,461 | 14.5% |
| **Anxiety Disorders** | 2,402 | 2.8% |
| **Top 5 Total** | 81,194 | 93.5% |
| **Other** | 5,644 | 6.5% |

Source: IP data as of 2/28/13

The activities targeted to support care of these diagnoses during the year included:
1. Monitoring providers for adherence to the clinical practice guidelines addressing treatment of mood disorders, substance abuse, and ADHD (see Section IX) as outlined on the provider website. A written review of identified clinical documentation deficiencies is provided in writing to the provider with appropriate follow-up based on Magellan policy.
2. Development of a Performance Improvement Project to improve coordination of care with primary care physicians, who are frequently involved in psychotropic medication provision and monitoring of labs. Primary care physicians now prescribe the majority of ADHD medications and Antidepressants, and about 20% of all antipsychotics. Workshops have been presented to six inpatient psychiatric facilities on the benefits of good discharge planning and coordination of care with primary care physicians, who can ensure that members with psychiatric and medical co morbidities have a single health care manager in the community to oversee their health needs.
3. Development and implementation of an action plan to increase follow-up rates for mental health appointments. Though improvement is seen, results remain below established goals.

## III. Accessibility and Availability of Services

### A. Telephonic Accessibility

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

The following table presents the call volume, ASA, and abandonment rates from March 1, 2012 to Feb 28, 2013. The goal for abandoned calls is 5% or less, and the goal for ASA is 30 seconds or less. Since implementation of services by Magellan on March 1, 2012, telephone responsiveness goals for call abandonment rates and average speed of answer have been met each month.

| Calls | March | April | May | June | July | Aug | Sept. | Oct. | Nov | Dec | Jan-13 | Feb-13 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Received | 13,199 | 10,774 | 11,241 | 10,978 | 9,466 | 8,509 | 8,676 | 9,845 | 8,375 | 8,512 | 11,152 | 8,293 | 119,020 |
| Answered | 12,975 | 10,751 | 11,136 | 10,882 | 9,342 | 8,301 | 8,526 | 9,648 | 8,138 | 8,347 | 10,891 | 8,121 | 11,7058 |
| Abandoned Calls | 224 | 23 | 85 | 76 | 93 | 169 | 103 | 139 | 237 | 165 | 199 | 111 | 1,624 |
| Aband. % | 1.70% | 0.21% | 0.76% | 0.70% | 0.98% | 2.00% | 1.20% | 1.41% | 2.80% | 1.90% | 1.78% | 1.34% | 1.39% |
| ASA (seconds) | 11 | 01 | 03 | 04 | 04 | 10 | 06 | 09 | 15 | 10 | 09 | 07 | 07 |
| AHT* (Min/Secs) | 9:25 | 7:53 | 7:42 | 7:28 | 6:29 | 6:22 | 6:34 | 6:10 | 6:26 | 6:18 | 6:07 | 6:15 | 6:38 |

*AHT = Average handle time

**B. Accessibility of Services (Geo-access & Density)**

Magellan maintains a behavioral health services provider network consisting of psychiatrists, psychologists, social workers, licensed professional counselors, and other service providers. Members have access to qualified providers who have experience with multiple special populations, including children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities. Efforts are made to recruit, retain, and develop a diverse provider network. Recruitment may include the assistance of local consumer advocacy and other community-based groups.

Magellan has established processes that address network definition and recruitment. Workgroups review the network geographic access and appointment availability data, the results of member satisfaction surveys, and member/family complaints to identify gaps in the type, density, and location of behavioral health providers in Magellan's network. The workgroup also monitors gaps in services and other culture specific provider service needs. When gaps are identified, the Network Services Department develops a provider recruitment plan and monitors its effectiveness in filling the gaps.

Total provider density is routinely monitored, with targeted goals for physicians and non-physicians (psychologists, and masters prepared therapists). The statewide goal of having 224 physician prescribers in the Louisiana Medicaid network was met. Magellan enrolled a total of 342 physician prescribers. However, though the total goals were met, individual Parish physician goals were met for only 30% of the Parishes in Louisiana. The 45 parishes not meeting the physician prescriber enrollment goals were primarily in rural areas. Twenty-five of these parishes have a population of 6,000 members or less. Only one parish of the 19 that met the physician goal had a population of less than 6,000 members. Magellan network staff continues

to monitor for new or existing providers in any area of need and work to recruit for the network. Please refer to Appendix for provider density by Parish.

Geographic access is monitored to ensure that contracted practitioners and facilities are available in the communities in which members reside. Overall, 96.9% of members have access to a provider within an average distance of 10.6 miles (refer to table below). On an aggregate basis depending on type of provider, this meets the established goals of distance ranges from 30 to 60 miles. Results by provider type as of mid-January 2013 are presented in the table below.

| Member Group | Access Standard | Percentage of Members with Desired Access | Average Distance to Choice of Provider (distance in miles) |
|---|---|---|---|
| Inpatient: Urban/Suburban | 1 provider in 30 miles | 100.0% | 2.6 |
| Inpatient: Rural | 1 provider in 60 miles | 99.8% | 11.9 |
| RTC Detox: Urban/Suburban | 1 provider in 30 miles | 98.0% | 6.1 |
| RTC Detox: Rural | 1 provider in 60 miles | 96.6% | 26.5 |
| RTC Rehab: Urban/Suburban | 1 provider in 30 miles | 91.0% | 12.5 |
| RTC Rehab: Rural | 1 provider in 60 miles | 88.4% | 30.5 |
| Crisis Response: Urban/Suburban | 1 provider in 30 miles | 100.0% | 1.6 |
| Crisis Response: Rural | 1 provider in 60 miles | 99.9% | 8.0 |
| Non-Medical Group Home: Urban/Suburban | 1 provider in 30 miles | 89.7% | 12.2 |
| Non-Medical Group Home: Rural | 1 provider in 60 miles | 78.6% | 32.9 |
| OBH Clinics: Urban/Suburban | 1 provider in 30 miles | 100.0% | 3.3 |
| OBH Clinics: Rural | 1 provider in 60 miles | 99.9% | 10.1 |
| MH Rehab: Urban/Suburban | 1 provider in 30 miles | 100.0% | 2.4 |
| MH Rehab: Rural | 1 provider in 60 miles | 99.9% | 11.8 |

| Member Group | Access Standard | Percentage of Members with Desired Access | Average Distance to Choice of Provider (distance in miles) |
|---|---|---|---|
| Multi-Systemic Therapy: Urban/Suburban | 1 provider in 30 miles | 98.2% | 5.0 |
| Multi-Systemic Therapy: Rural | 1 provider in 60 miles | 99.3% | 20.5 |
| Psychiatrists: Urban/Suburban | 1 provider in 30 miles | 100.0% | 1.2 |
| Psychiatrists: Rural | 1 provider in 60 miles | 99.9% | 7.4 |
| Other Licensed Practitioners: Urban/Suburban | 1 provider in 30 miles | 100.0% | 0.9 |
| Other Licensed Practitioners: Rural | 1 provider in 60 miles | 100.0% | 5.2 |

**Appointment Availability**

Appointment availability is monitored to ensure timely access based on the urgency of the situation or the presenting issue. Appointment standards for the Louisiana population are:

- Emergent - ≤ 1 hour
- Urgent - ≤ 48 hours
- Routine - ≤ 14 calendar days

During the first year of implementation, Magellan has monitored appointment access based on several different metrics including:

A. Time from request for service to determination
B. Time from request for service to member accessing service
C. Member satisfaction with access to care
D. Member grievances regarding access to care

Findings based on each of these measures are presented below.

**Measure #1**: Percent of members authorized for service with determination within required time frames

| Date | Emergent | Urgent | Routine |
|---|---|---|---|
| Q1 | 77% | 100% | 100% |
| Q2 | 99% | 100% | 100% |
| Q3 | 99% | 100% | 100% |

| Date | Emergent | Urgent | Routine |
|---|---|---|---|
| Q4 | 99% | 100% | 100% |

With the exception of Q1 Emergent results at 77%, all other quarters exceeded the established decision determination timeliness of 95% or above.

**Measure #2:** Percent of members attending an appointment within time standards defined as date of request for service and date of first claim post request for service.

| Access Type | Performance Indicator | Goal | 3/1/2012 – 2/28/3013 |
|---|---|---|---|
| Emergent | ≤ 1 hour | ≥ 95% | 93.5% |
| Urgent | ≤ 48 hours/2 calendar days | ≥ 95% | 71.2% |
| Routine | ≤ 14 calendar days | ≥ 70% | 74.7% |

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

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

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

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

**Measure #5** –Member grievances related to access

| 1st Qtr 2012 | 2nd Qtr 2012 | 3rd Qtr 2012 | 4th Qtr 2012 | 1st Qtr 2013 |
|---|---|---|---|---|
| 0 | 0 | 1 | 2 | 4 |

As the data in the measures above shows, the determination for member access is made promptly when a call is received. Member access from time of call to date of service when reviewed in conjunction with satisfaction survey results offers an opportunity for further improvement, though member grievances related to access are low. The appointment access measure with the largest discrepancy between date of request and service date relates to urgent appointment access, which is 23.8 percentage points lower than established goal.

Factors which make reliance on Measure #2, *Percent of members attending an appointment within time standards defined as date of request for service to date of first claim post request for service,* problematic include:

- Member decides not to attend scheduled appointment
- Member makes appointment outside of standards based on their convenience
- Member decides appointment is no longer urgent
- Provider requests appointment authorization and classification is based on provider information, not member perception of need
- Magellan staff does not classify request correctly
- Magellan staff does not enter complete data
- Data skew due to extreme outliers

Magellan continues to address ensuring members obtain access within appropriate timelines based on the identified need. An additional measure will be implemented for the 2013 contract year. Plans are in place to conduct a quarterly survey of provider offices to obtain information regarding next available urgent and routine appointment openings. In addition to obtaining provider appointment access data, this initiative offers the further benefit of reinforcing access standards with providers.

## IV. Workplan Evaluation: Enterprise & Customer Performance Measures

The LA CMC developed a comprehensive quality workplan with goals and prioritized objectives including customer requirements. The LA CMC's 2012 Quality Workplan contained 9 goals and 13 objectives. Of these 9 goals, 6 were fully met and three were partially met. A review and discussion of activities and results related to each of the goals is presented below.

**Goal 1. Ensure adequate access to care through:**

a. Telephone responsiveness of member services to requests for services
b. Timely access to different levels of care
c. An adequately developed provider network

**Findings/Activities**

- Met established Member Services telephone responsiveness goals each month for both average speed of answer (ASA) and call abandonment rate (CAR).
- Met established geo access goals for over 96.9% of members; members have access to a provider within an average distance of 10.6 miles.

- Met statewide goal of ≥ 224 physician prescribers in the Louisiana Medicaid network; enrolled a total of 342 physician prescribers. Though total goals were met, individual Parish physician goals were met for only 30% of the Parishes in Louisiana. Network is working to enroll additional providers in the more rural areas of the state. One initiative in process to increase access to physicians in rural areas is an agreement reached between Magellan, Office of Behavioral Health, and Medicaid to allow selected small rural hospitals that provide psychiatric services to forego the extensive credentialing process required of larger hospitals in urban areas. This will increase Magellan's ability to provide psychiatric services to individuals in under-served areas.
- Partially met Access to Care goals for emergent, urgent, and routine appointments. Several measures are used to monitor this process as discussed under Section III Access & Availability above. Magellan has established a workgroup to promote consistency in documentation of requests in the Magellan data systems. Reliability trainings will help ensure that consistent clinical decision making is occurring so that members are assigned to the correct level of care in a timely manner.

**Goal 2: Track and enhance outcomes through monitoring of:**

a. 30-day mental health readmission rates
b. 7-day mental health follow-up rates
c. 30-day mental health follow-up rates
d. Over and under utilization rates
e. Adult high service utilizers
f. Admission rates to inpatient psychiatric facilities & average length of stay
g. Providers through treatment record reviews to ensure that services are of high quality and that providers are adhering to clinical practice guidelines

**Findings/Activities**

- 7-day and 30-day follow-up appointments with licensed mental health professionals (LMHP's) revealed progress toward achieving established goals, although the goals were not fully met. For 7-day follow-up the annual result was 29.1%, which is 15.9 percentage points below the goal of 45%. The 30-day rate was 48.4%, which is 16.6 percentage points below the goal of 65%. Quarterly monitoring results are presented in the table below. An action plan has been developed to address the identified barriers and opportunities related to these measures. Barriers identified include: lack of available appointments with mental health professionals in selected areas; members elect not to attend scheduled appointment; and providers who only accept walk in appointments and will not schedule a 7-day appointment.

| 2012 | 30-day Readmit | FU 7-day % | FU 30-day % |
|---|---|---|---|
| **1st Quarter** | 12.25% | 26.60% | 46.50% |
| **2nd Quarter** | 13.03% | 28.13% | 48.10% |
| **3rd Quarter** | 12.86% | 27.53% | 50.03% |
| **4th Quarter** | 13.93% | 30.30% | 47.80% |
| **Contract Yr** | 13.09% | 29.10% | 48.40% |

- Over/under utilization measures (including average length of stay) and comparison to threshold, where available are discussed under Section XXI. Evaluation of Over/Under Utilization of Services.
- Coordination of care between psychiatric inpatient settings and Primary Care Physicians was identified as an opportunity for improvement through the Treatment Record Review process. A formal Performance Improvement Plan (PIP) was initiated to increase coordination of care between inpatient facilities and the member's PCP. Initial results from interventions with selected facilities show improvement in coordination of care with PCPs.
- Magellan partnered with TracFone to provide an initial segment of our 1915(i) population with free cell phones to facilitate member communication with the LA CMC and their provider(s).
- Analysis of the inpatient psychiatric rates indicates that approximately 89% inpatient admissions are referred by emergency departments. 241 members were found to have had six or more inpatient admissions by the end of the contract year and 5 members had between 18 and 34 inpatient admissions. Magellan has convened a workgroup to address this high readmission utilization rate. A flag will be added to Magellan's data system to identify these high utilizers when a request is made for authorization for another inpatient admission, at which time the case will be reviewed by a physician advisor to make sure that the member meets medical necessity criteria for inpatient treatment.

**Goal 3: Ensure provider and member satisfaction with Magellan services**

**Findings/Activities**

- The provider satisfaction rate of 80.2% exceeded the established threshold goal of 75%.
- The member overall satisfaction rate of 85.4% for Minors exceeded the established threshold goal of 85%.
- The member overall satisfaction rate of 79.7% for Adult members was 5.3 percentage points below the threshold goal; an action plan is under development to address.

**Goal 4: Work to achieve URAC accreditation**

**Findings/Activities**

- In preparation for the URAC review in the fall, the LA CMC went through an in-depth accreditation pre-assessment review by the National Quality Director who coordinates accreditation activities related to URAC across Magellan. Areas of strengths and needs were identified and are being addressed. The application for accreditation was submitted to URAC in the January 2013 with the site visit anticipated during October/November 2013. Based on the pre-assessment findings and the CMC preparations, a successful review is anticipated.

**Goal 5: Track and address patient safety and quality of care issues by:**

a. Dedicating a QI staff member to catalog and investigate Adverse Incidents (AI's) and Quality of Care (QoC), formation of an interdisciplinary committee that meets weekly to

address AI's and QoC's that reviews AI's, QoC's, allegations against providers, as well as applications for membership/renewal in the provider network.

b. Hiring a Compliance Officer dedicated to ensuring that the rights of members are safeguarded.
c. Developing a Regional Network Credentialing Committee to review safety issues
d. Implementing a Treatment Record Review Process

**Findings/Activities**

- Actions a, b, c, and d were fully accomplished. The CMC has established a thorough policy and procedure for capturing and addressing AIs and QOC concerns. These reports are sent to the Magellan Corporate legal office, the LA CMC Compliance Officer, and/or to the LA CMC CMO for initial review and recommendations. Each is then brought to a weekly interdisciplinary committee meeting where the issues are carefully examined. If a concern rises to a significant level, the case is presented at the RNCC meeting for review and further action. Providers with issues may also be referred to the Quality Treatment Record Review team, the Special Investigation Unit, and the Network committee for additional inquiry.
- Treatment record reviews of all inpatient psychiatric hospitals with 25 or more admissions were conducted during the year. The QI review team completed reviews of 39 inpatient psychiatric hospitals. Quality of care and/or documentation issues were identified and addressed through formal and informal corrective action plans (refer to Section VIII. Treatment Record Review for further detail).

**Goal 6: Ensure that appeals are resolved in a timely fashion**

**Findings/Activities**

This goal was partially met. The Appeals Resolution timeliness was 93.8%, 1.2 percentage points lower than the established goal of 95%. Process analyses are underway to determine barriers and opportunities for improving the efficiency of internal decision-making and processing procedures.

**Goal 7: Promote positive relationships with providers by paying claims in a timely and accurate manner**

**Findings/Activities**

All claims indicators met goal including Financial Payment Accuracy with a goal of 97%, Claims Procedure Accuracy with a goal of 98%, Claims Turnaround within 30 days with a goal of 95%, and Claims Turnaround within 45 days with a goal of 99%.

The table below displays the accuracy and turnaround times by month through the first calendar year of operations. Metrics assessed to determine financial accuracy can be found in the Data Quality Policy in Appendix E.

| 2012 | March | April | May | June | July | Aug. | Sept. | Oct. | Nov. | Dec. |
|---|---|---|---|---|---|---|---|---|---|---|
| **Financial Accuracy %** | 100 | 100 | 99.57 | 98.26 | 99.34 | 99.87 | 99.79 | 98.99 | 99.96 | 99.89 |
| **Procedural Accuracy** | 100 | 99.83 | 99.11 | 98.97 | 99.31% | 99.45 | 99.43 | 99.15 | 99.47 | 99.18 |
| **Turn Around (30-days)** | 100 | 99.95 | 99.96 | 99.90 | 99.97 | 99.91 | 99.98 | 99.97 | 99.84 | 99.84 |
| **Turn Around (45 days)** | 100 | 100 | 99.99 | 100 | 100 | 99.98 | 99.99 | 99.98 | 99.93 | 99.96 |

**Goal 8: Develop a provider dashboard that assists providers in tracking their own performance measures (e.g., census rate, readmission rates, ALOS).**

**Findings/Activities**

The dashboard was successfully rolled out for inpatient and substance abuse residential treatment providers on November 30, 2012. The metrics included average length of stay, referral to the community, thirty day readmission rates, seven day follow-up rates, and thirty day follow-up rates. The second dashboard roll-out occurred on March 6, 2013 and a webinar was conducted the morning of March 21 with over 80 providers. Each provider may access the dashboard through Magellanprovider.com. The second roll-out metrics focus on community-based programs and provide data on number served, number served by diagnostic category, and average number of services per member by provider. The data can also be viewed in graph format. The final planned roll-out will occur in either the second or third quarter of 2013 and will feature an enhanced dashboard with "drill through capability" so that providers may see individual member data.

**Goal 9: Develop the Children's Coordinated System of Care and enroll 2400 members**

**Findings/Activities**

CSoC Program implementation was completed with the majority of elements established, although the Family Service Organizations (FSO) originally recruited had difficulty sustaining their business models and the State transitioned to one statewide FSO. The total enrollment in the five WAAs during the first contract year was 1,295. At the end of the contract year, there were 723 CSoC children enrolled with the WAAs. The maximum census at any one time across the five WAAs in the first year was expected to be 1200. At present, the State is working on a plan to increase the number of CSoC implementing regions, which should increase the number of referrals to the CSoC program (refer to description of the CSoC program in Section XX).

Each of the prioritized objectives listed above is discussed in more detail further in this evaluation and Appendix C contains the yearly status review of the 2012 LA CMC Quality Improvement/Clinical Management Work Plan performance measures.

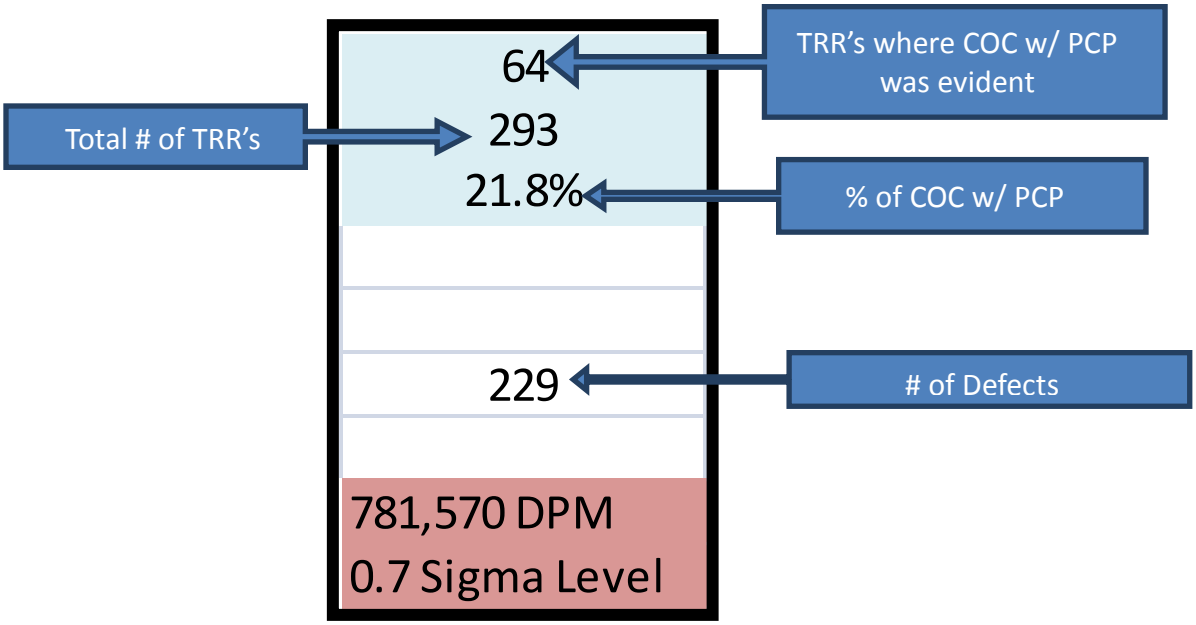
## V. Quality Improvement Activities, Performance Improvement Projects, & Six Sigma Projects

The LA CMC initiated 4 clinical and 2 service Performance Improvement Projects during this first contract year. A summary of each activity is described below.

### 1. Improve Coordination of Care with Primary Care Physicians upon Discharge from Psychiatric Hospitals

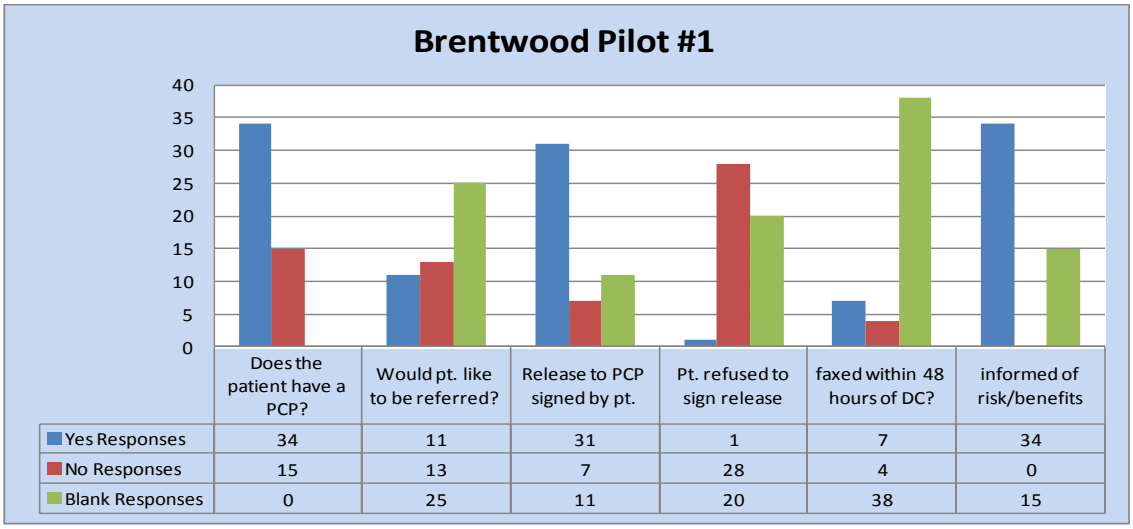
Magellan implemented this performance improvement project (PIP) to address the stated Louisiana Behavioral Health Partnership (LBHP) goal to increase the integration of mental healthcare with physical healthcare. This PIP focuses on one aspect of integration, improving the coordination of care with the primary care physician (PCP) when a member is discharged from acute inpatient psychiatric treatment.

Magellan employed the Six Sigma DMAIC model as a framework for conducting this project. In September of 2012, staff completed an analysis of the findings from treatment record reviews conducted with inpatient facilities, looking in particular for problems that may contribute to the psychiatric readmission rate. Results for coordination of care elements collected through the record review process identified coordination of care with the patient's PCP at discharge with an initial result of 23% as an opportunity for improvement. A Sigma analysis and Defective Parts per Million analysis was conducted and showed unacceptably high rates as shown below.




Magellan staff developed two one-month pilot projects in October of 2012 at Brentwood Psychiatric Hospital in Shreveport. Brentwood was chosen since it is Magellan's largest provider of inpatient psychiatric services. Pilot project efforts initially focused on understanding the processes involved in making a PCP follow-up appointment. The results of the Brentwood pilot process assessment are presented in the graph below. One of the first

observations made was that 15 out of 49 members did not know they had an assigned PCP through Bayou Health, and only 45% wanted a referral to a PCP.




| | Does the patient have a PCP? | Would pt. like to be referred? | Release to PCP signed by pt. | Pt. refused to sign release | faxed within 48 hours of DC? | informed of risk/benefits |
|---|---|---|---|---|---|---|
| Yes Responses | 34 | 11 | 31 | 1 | 7 | 34 |
| No Responses | 15 | 13 | 7 | 28 | 4 | 0 |
| Blank Responses | 0 | 25 | 11 | 20 | 38 | 15 |

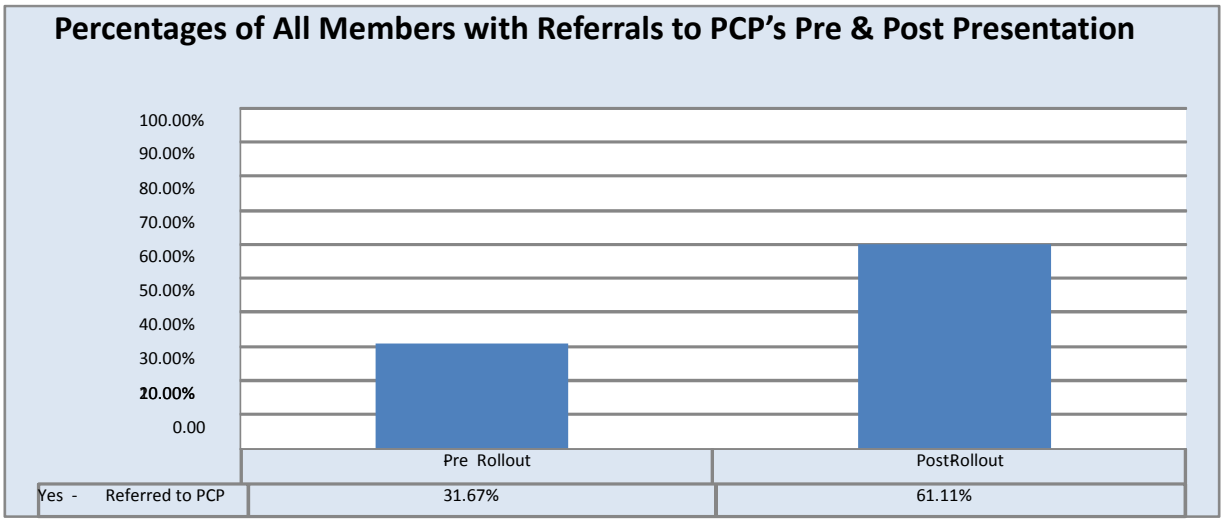
The sub-processes involved in coordinating care with PCP's include:

- Buy-in from facility executives & physicians regarding the importance of this process, so social services staff has direction to make appointment
- Obtain consent from member to schedule PCP appointment (found to be a barrier since Brentwood reported many children are hospitalized without a guardian present to sign consent forms)
- Determine the member's PCP (found to be a barrier since many members do not know their PCP and it is difficult for psychiatric hospitals to obtain this information from the Bayou Health Plans).
- Need for attending physician to write discharge order for follow-up appointments with PCP
- Need for social service or nurse to schedule the appointment with the PCP
- Providing the member with appointment details such as time and location at discharge
- Need to verify through claims data that member has attended appointment

Although Bayou Health Care assigns a PCP to each member, a large percentage of members do not know their assigned PCP, even though listed on their ID cards. Further, many members do not bring their ID cards with them when hospitalized. Brentwood and other providers have reported it is sometimes a lengthy and time consuming process to determine the PCP through the Bayou Health Plans. Hospital providers must provide many services quickly and efficiently in a short period of time, since the average length of stay for psychiatric inpatients across the system is only seven days. Due to multiple priorities, discharge planning often gets over-looked or de-emphasized given all the clinical activities to be accomplished. Magellan is working with the Bayou Health Plans to obtain access to their PCP databases so that at the time authorization is provided for inpatient services, staff can also provide the facility with the name and phone number of the member's PCP. If the facility has this information at the time of admission,

including obtaining a follow-up appointment with the PCP can be incorporated as part of the discharge planning process.

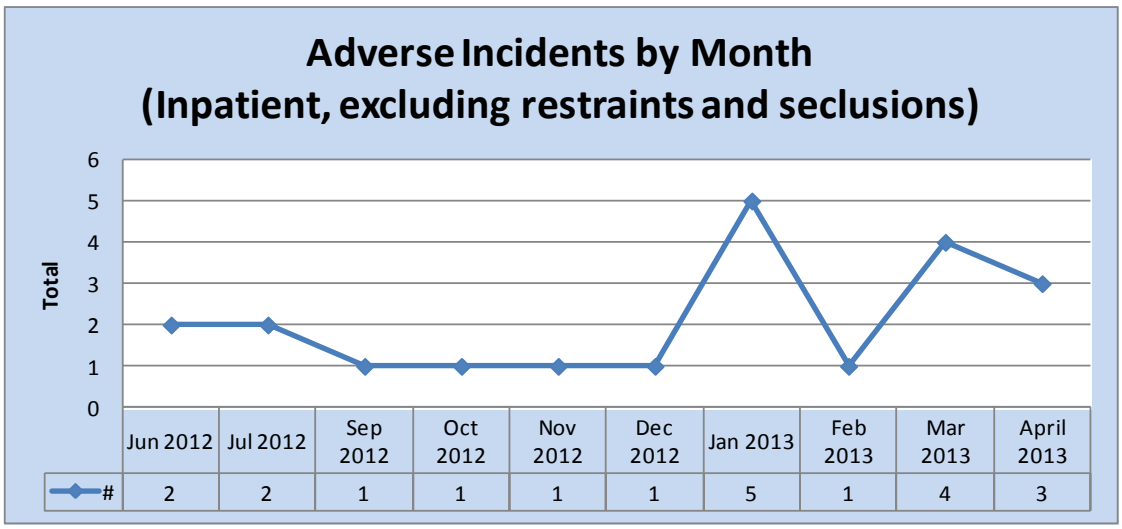
Five face-to-face presentations with facility providers have been completed since February of 2013. Facilities include Willis Knighton Hospital (WK), LSU Shreveport, East Jefferson, Greenbrier Behavioral Health Hospital, and Our Lady of the Lake. Preliminary findings indicate these presentations have resulted in increased PCP appointment rates (see graph below). Review of discharge records of 100 randomly selected members from WK, LSU, East Jefferson, and Greenbrier prior to the presentation and 100% of the discharge charts following the presentation, show improvement in the rate of coordination of care with PCPs, with an overall increase of almost 100% (see graph below). It should be noted that most of the increase was centered in two of the four facilities. One facility's rate was already high and may have reached a "ceiling" level.




Coordination of care with PCPs is widely recognized as a challenging problem for managed care companies. Despite the challenges involved in changing the mindset of psychiatric hospitals used to doing business in an environment with less scrutiny and oversight, the potential benefits for Louisiana citizens with severe mental illness are great. Magellan has identified the barriers and opportunities to improve discharge planning. It is recommended this PIP be continued for the next year.

**2. Improve Reporting of Adverse Incidents**

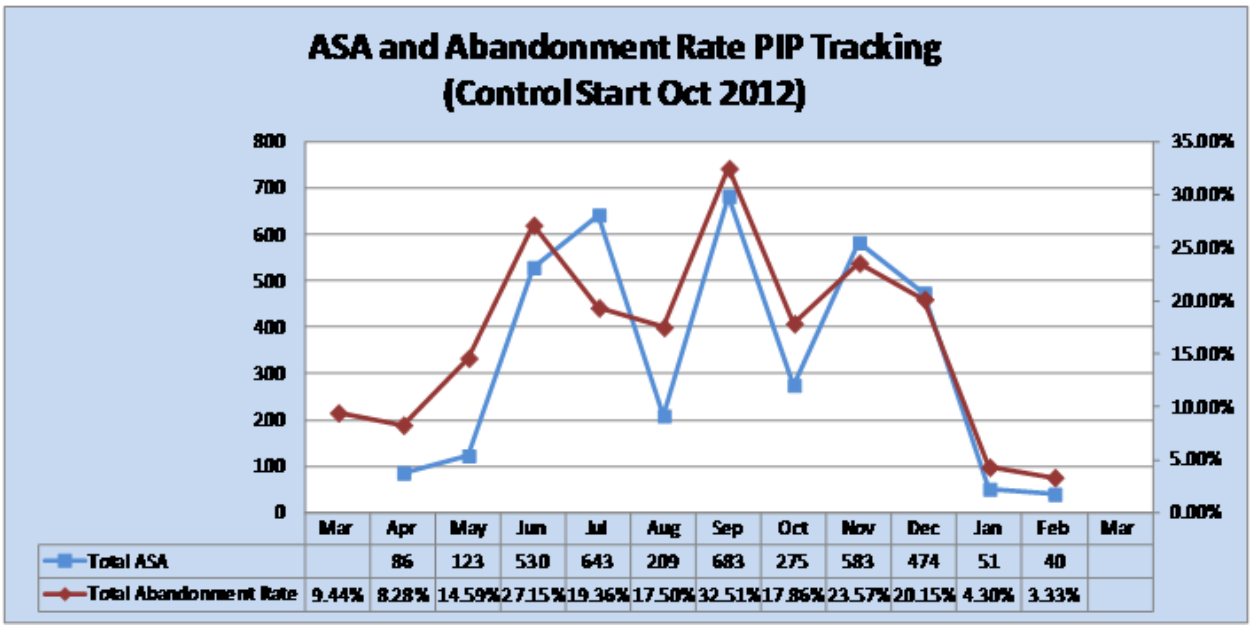
During the first 10 months of the contract year, Magellan staff reported an average of 1.33 adverse incidents per month. Review of the information reported indicated that staff may not know to report or understood reporting was needed for potential adverse incidents that came to their attention. A refresher training was conducted with care managers which emphasized the need to report and the types of incidents to be reported. After completion of the training, the average rate of reporting from January to April 2013 increased to an average of 3.25 adverse events reported per month (see figure below). It was determined to offer periodic refresher trainings to reinforce this process going forward.




**3. Improve Telephone Responsiveness of Care Managers**

Between March and October 2012, Care Management call abandonment rates (CAR) fluctuated between 8% and 27%, while the average speed of answer (ASA) increased to over 600 seconds in July 2012. Magellan performance goals for the Care Management Department are targeted to a 90 second ASA and a 5% abandonment rate. As the graph below shows, results exceeded established goals.

A PIP was initiated in October 2012 with completion of a process analysis of Care Manager workflows by the CMC's Six Sigma Black Belt. This project included data analyses and assessment of opportunities for improvement to gain efficiencies. Based on findings, modifications were made in the Care Manager workflows, including provision of reference sheets to decrease placing callers on hold and interventions to match staffing patterns to call volume. With workflow modifications and the additional supports in place, the ASA decreased to 275 seconds in October and the abandonment rate dropped to 17.9%. November saw an uptick, but December showed a decrease to 474 seconds ASA with 20.2% abandonment rate. An additional intervention was implemented in January 2013 to further improve ASA and CAR rates. Providers are now able to fax requests for authorizations. Data from March 2012 through February 2013 is presented in the table below. As the results show, significant improvement was seen in January and February, once the additional intervention was implemented. Measures will continue to be monitored until stabilization of data is seen.




**4. Improve Patient Safety**

The Louisiana CMC has been integrated into a Magellan Behavioral Health system wide patient safety performance improvement project. Magellan created and conducts an annual survey of patient safety programs and practices currently in place at inpatient facilities within its clinical networks. The LA CMC is included in this patient safety effort. The survey, based on industry and accreditation standards, asks facilities about areas covered by their patient safety programs, with a specific focus on behavioral health, including whether there are policies and protocols for:

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

The results provide a comprehensive picture of areas in which facilities currently address patient safety. Magellan shares results with the facilities and shows how they compare with aggregate results from the rest of the facilities in the survey. The results become a meaningful part of a facility's records that can assist with re-credentialing efforts.

Five items were identified by Magellan national as meaningful opportunities for improvement across the provider networks. The results system-wide and specific to the State of Louisiana are provided in the table below:

**Magellan Safety Survey-2012 Results**

| Question | MBH N= 2,296 | LA N=34 | Goal | Goal Met/ Not Met |
|---|---|---|---|---|
| Response Rate | 36.6% | 41.0% | TBD | Baseline |
| Facilities or practitioners sending discharge summaries and/or labs to PCPs | 50.6% | 68.8% | TBD | Baseline |
| Facilities or practitioners discussing history of adverse medication reactions with patient's PCP | 44.7% | 48.5% | TBD | Baseline |
| Facilities that have safeguards in place for seclusion and restraints | 89.8% | 100% | TBD | Baseline |
| Facilities or practitioners that review medication profile with provider at time of transition | 82.3% | 82.1% | TBD | Baseline |
| Facilities or practitioners that review medication profile with patient at time of transition | 92.2% | 98.8% | TBD | Baseline |

Magellan Behavioral Health of Louisiana identified the questions associated with coordination of care with PCP and medication management as meaningful opportunities for improvement at the CMC level. Both coordination of care and discharge process/planning have been identified by the UM and QI departments as areas that require improvement. Further, the results of the Treatment Record Reviews (TRR) conducted by QI support the need for improvement. The LA CMC has developed a PIP that is underway and shows promising results. In addition, the QI department has developed a Discharge Treatment Planning training to be placed on the Provider Website to help providers increase coordination of care at discharge.

The following metrics will be tracked in the coming year:

- Provider response rate to patient safety activity survey
- Percentage of facility staff and/or practitioners that send discharge summaries and/or labs to patient's PCP
- Percentage of facility staff and/or practitioners that discuss history of adverse medication reactions with patient's PCP
- Percentage of facility staff and/or practitioners that review medication profile with provider at time of transition
- Percentage of facility staff and/or practitioners that review medication profile with patient at time of transition.

**5. Improve Access to care for Emergent, Urgent, and Routine Appointments**

This performance improvement project provides a baseline for access to care based on a members need for emergent, urgent, or routine appointment access. Several measures are included under this PIP, since there are confounding factors which can affect measurement results as discussed earlier under Section III Access and Availability. This PIP is planned for continuation in Year 2 as there are opportunities for improvement.

**6. Improve CSoC Service Authorizations at Time of First Review**

This PIP was initiated to monitor the number of CSoC children who received authorizations for additional CSoC services at the 30-day review. 96% percent of children were found to have

authorizations. Due to the high rate of compliance with the required measure, CSoC and QI staff determined to add a further measure and look at the number of children with authorizations who had claims for additional CSoC services. Findings revealed that 43% of these children had claims for services. This finding offers an opportunity for improvement and this PIP will be continued during Year 2. CMC staff is developing interventions to improve the rate at which these children receive additional CSoC services. The initial step is to survey CSoC families to determine what barriers may have prevented access to services in order to facilitate development of targeted interventions.

In addition, several new PIPs are under consideration. Potential topics for formal PIP development include:

- Improve Follow-up after Hospitalization – 7-day & 30-day metrics
- Improved Identification & Referral of High Utilizing Members (defined as having $\geq$ 2 IP or 4 ER visits in a 12 month period) to ACT or PSR Services
- Improve Use of CANS to Demonstrate Improved Outcomes

LA CMC staff in collaboration with OBH will review proposed topics and select the additional PIP to be addressed during 2013.

## VI. Care Management Initiatives

Since "Go Live" on March 1, 2012, the Utilization Management Department identified and implemented several innovative strategies resulting in quantifiable improvements to Care Management service delivery. Each initiative is summarized below:

**A.** Team Alignment

- Improved clinical and operational efficiencies by appointing an additional Care Management Supervisor and aligning teams to each of four supervisors according to clinical function.

- Assigned responsibility for managing incoming authorizations for inpatient, outpatient, and residential levels of care, handling crisis calls, and reviewing paper based authorization requests for community-based services including ACT, CPST, MST, FFT, Homebuilders and Crises Services to the Intake/Triage team.

- Created an Inpatient Concurrent Review Team to manage daily inpatient membership for approximately 65 network inpatient psychiatric inpatient facilities and those out-of-network facilities from whom members are receiving care.

- Established a Residential Concurrent Review Team to manage daily membership for all LBHP substance abuse residential providers. Additionally, beginning in January 2013, the team began managing other residential levels of care including psychiatric

residential treatment, therapeutic group homes, therapeutic foster care, and non-medical group homes.

- Established Resiliency/Recovery Care Management program to provide intensive care management services to high utilizing members in collaboration with individual members, their families, stakeholders, and other involved parties to assure member needs are being addressed in the community.

Division of our care management staff into teams with specific functions has increased both individual and team accountability. It has had an overall positive impact on utilization rates and helped with cost containment.

**B. Independent Assessment/Waiver Eligibility Process**

Magellan is tasked with the clinical eligibility determination for Medicaid 1915(i) waiver services. The clinical determination for member eligibility for services under this waiver was initially based on an Independent Assessment completed and submitted by a network provider. Based on waiver requirements, the Independent Assessor could not be the service provider for the member. This was quickly identified as a barrier to access to waiver services since the statewide network of Independent Assessors was not sufficient to enroll members in timely fashion. To address this barrier, the process was modified to allow certified providers to collect information for the assessment which is then evaluated independently by Magellan. This initiative removed an access to care barrier and increased the daily volume of IAs received from approximately 65 to over 100 between May and December and admits per thousand to CPST (waiver services) has improved from 1.81 in April 2012 to 10.98 in November2012.

**C. Paper Based Authorization Process**

The LA CMC authorizes various community-based levels of care including ACT, CPST, PSR, FFT, MST, Homebuilders, and Crisis Services. The complexities surrounding the authorizations for these services resulted in high call abandonment rates and long ASA times. Beginning January 1, 2013, the authorizations for these services were shifted from telephonic reviews to paper based reviews. Although it is early into the transition, so far the result has been a dramatic reduction in call abandonment rates and average speed of answer. The LA CM MTD report on ASA and Abandonment Rates is as follows:

| Month | Abandonment Rate | ASA |
|---|---|---|
| **09/2012** | 33% | 683 |
| **10/2012** | 18% | 275 |
| **11/2012** | 24% | 583 |
| **12/2013** | 20% | 474 |
| **01/2013** | 17% | 121 |

**D. Care Manager Report Card Implementation**

Beginning in August 2012, CMC Managers initiated development of Care Manager (CM) report cards. The report card consists of specific performance metrics to which each CM is accountable. Each metric has an established benchmark which the CM is expected to meet. For the inpatient concurrent review team there are several key performance variables – average length of stay, Physician Advisor referral rate, denials, concordance, and Qfiniti scores. Since the implementation of report cards positive performance trends have been seen. The LA CMC overall average length-of-stay and readmission rate are also trending down. These trends correspond with the implementation of performance monitoring.

**E. Care Coordination with Health Plans**

The coordination of care is a key component of effective utilization management. The LA CMC has coordinated with our Bayou Health medical providers in the development and implementation of joint clinical rounds. Magellan has assigned to each of the Bayou Health plans a care manager who participates with the health plan in these clinical case conferences when the member is served by both Magellan and the health plan. Workflows are under development for referring members to their Bayou Health primary care providers. In addition, a proposal for Magellan system modifications to enable the CMC to more readily capture the referral information for reporting purposes is in process. Separate fax number, email, and phone messaging is also being set up for more efficient management of CSoC referrals. Finally, the Recovery/Resiliency care management team (RCM) provides care coordination with various community-based providers and each of the Bayou Health Plans for members with the highest needs. The RCM team focuses on members who have frequent readmissions to higher levels of care and who have various co morbid conditions.

**F. Training Alerts**

The LA CMC manages a variety of inpatient, outpatient, and community-based services for the LBHP. Stakeholders include various state government offices including Medicaid, Office of Behavioral Health, Department of Child and Family Services, Office of Juvenile Justice and the Department of Education. Magellan's Coordinated System of Care (CSoC) partners include wraparound agencies (WAAs) and family support organizations (FSOs). The nuances involved with the authorization and management of these covered services combined with the requirements of our customers brings many challenges – eligibility, data collection, information systems interface, and claims issues - all of which point to the need for the timely and efficient dissemination of information. As a result, the LA CMC UM team implemented the use of a standardized process for communicating important procedural changes. A Training Alert Template was developed to communicate such changes. The template is funneled through a single point for distribution to staff and housed in a shared drive accessible to all care management teams as well as other CMC managers. The implementation of training alerts has ensured that all care management staff receives the same notification of process and policy updates and should result in fewer questions and greater consistency of process application among care management staff. Closely tied to the implementation of training alerts to enhance efficiency was the implementation of process mapping (discussed next).

**G. Process Mapping**

Due to the complexity of service types, complex authorization requirements, and the potential for billing and claims errors, building authorizations correctly and establishing continuity and consistency among care managers became a challenge for the LA CMC. To improve efficiency and increase understanding of work responsibilities, the CMC recruited a process expert (Six Sigma black belt) who was tasked to shadow team members, map processes and develop workflows. More than 200 hours was spent over a 3 month period resulting in the development of 25 workflows, which captured in detail overall processes and instructions for building authorizations for nearly every LBHP level of care the CMC is responsible for managing. The result has been fewer claims discrepancies requiring reconciliation.

**H. Employee Council**

The UM teams will implement an employee council for 2013. The purpose of the council will be to provide an opportunity for employees to bring ideas for process improvements to the table for consideration. It will also provide a forum for an employee representative from each team to bring issues from a 'front line' perspective to be heard. The council will consist of CMC managers and an elected employee representative from each team. The representatives have been elected and the first meeting has been scheduled.

**I. Time Studies**

In the first quarter of 2013, time studies of work flows of the CM department were conducted by a Six Sigma black belt and team leadership. These studies helped to identify opportunities to improve efficiency and better understand staff work loads. By the end of the first quarter of 2013, all departments will have had a work flow analysis conducted to identify problems and barriers.

**J. Building Bridges**

The LA CMC residential team is working on a 'building bridges' initiative with the aim to streamline UM processes involving the Department of Child and Family Services (DCFS) and Office of Juvenile Justice (OJJ), as well as provide a systematic approach for managing membership in psychiatric residential treatment facilities (PRTFs).

**K. Monitoring of Outlier Provider Patterns**

The movement of the community-based authorization process to a fax-based system will result in a need to identify outlying requests and provider patterns. For 2013, the plan is to develop an effective system for redirecting and applying a qualitative review to outlier requests. In addition, a project has been initiated to identify unusual provider behavior (e.g., seeing members at unusual hours of the day, on weekends, and on holidays) that would trigger a quality of care review.

**L. Collaboration with Follow-Up Team**

Going into 2013, CM teams will be structured to partner with the follow-up team to identify opportunities for collaboration across teams, as it is realized that readmissions and follow-up rates are closely linked to appropriate discharge planning. The CMC is also carving out a

process to facilitate discharge planning for inpatients managed in intermediate/long term care facilities with the anticipated outcome of increasing community tenure for those individuals with high risk of re-institutionalization.

**VII. Clinical/Functional Outcomes Activities**

The LA CMC QI department works closely with the corporate outcomes department. As part of the implementation process, the following outcomes tools were identified:

- Telesage Outcomes Measurement System (TOMS)
- Child and Adolescent Needs and Strengths (CANS) Comprehensive LA
- Level of Care Utilization System (LOCUS)
- Child and Adolescent Level of Care Utilization System (CALOCUS)
- Addiction Severity Index (ASI)
- Child and Adolescent Severity Index (CASI)
- Consumer Health Inventory (in the RCM program only)
- Consumer Health Inventory – Child (in the RCM program only)

Magellan's goal was to have full functionality of online data collection for each tool to maximize ease of data entry, automate access for providers and Magellan, and provide raw data for production of reports. All the tools were accessible on 3/1/2012 with the exception of the LOCUS/CALOCUS, which became available later in March, although no tool has achieved full functionality yet. On 5/30/2012 an outcomes tool meeting was held to identify the barriers to full functionality and to develop a plan for a workgroup for each outcomes tool to be convened to determine the "value proposition" of each tool. These short-term focused workgroups are to have their value statements and recommended steps by the end of July 2013. The following table presents the outcome tools and their current functionality level.

**Table of Outcomes Tools and Functionality:***

| **Functionality** | **LOCUS** | **CALOCUS** | **ASI** | **CASI** | **LA CANS** | **TOMS** | **CHI/C** |
|---|---|---|---|---|---|---|---|
| Provider Access | | | | | | | |
| CA | **x** | | **x** | **x** | **x** | **x** | |
| Mp.com | **x** | | **x** | **x** | **x** | **x** | |
| Individual assessment | **x** | | | | **x** | **x** | **x** |
| Individual assessment over time | | | | | **x** | **x** | **x** |
| Provider Report | | | | | | **x** | |
| Magellan Access | | | | | | | |
| Individual assessment (over time) | | | | | **x** | | **x** |
| Provider Report | | | | | **x** | | **x** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Raw data | | | x | x | x | | x |
| Aggregate report | | | | | | | x |
| Member Access | | | | | | | |
| Member Report | | | | | x** | | x |

* No tool has provider access to aggregated or comparison report

**LA CANS Individual assessment compliant as member report

**Outcomes Tools and Functionality Detail**

- TOMS: The State holds the contract as part of a Data Infrastructure Grant and NOMS reporting. The decision was made early in implementation that Telesage would maintain the raw data and reporting (individual, provider, and state) and that Magellan would send to Telesage member information. Magellan, in turn, would receive access to TOMS data, although that has not occurred yet. The use of the TOMS was limited prior to Magellan and has decreased even further in the past three quarters.

- CANS LA: The CANS data system produces qualitative data that can be used to track the clinical progress of children in the CSoC system, although the data entry and recording has not yet become automated. It is unfortunate that Magellan is not allowed by the CANS intellectual copyright holder to create an online training system with automated certification-to-assessment access. The process to identify (through external training site) and contact certified providers is cumbersome. A barrier is that we do not have access to a fully integrated, electronic data warehouse of completed Comprehensive CANS. Efforts are underway to develop this capability.

- LOCUS: Contract executed after go-live for software installation, yet the software was never installed. Web-based assessment produces a PDF and data collection. Online Level of Need form could produce data on elements of LOCUS, but not raw data.

- CALOCUS: Contract executed after go-live for software installation, yet software was never installed and the decision was to not use the web-base in the interim due to cost of $1.50 per assessment. These are being completed on paper, although the numbers are unknown.

- ASI: Unknown use by providers. The ASI can be done through CA and mp.com online, but this is not being consistently used by providers.

- CASI: Unknown use by providers. CA and mp.com online for data collection but no reports on use.

- CHI/CHI-C: These are fully functional within the Recovery Care Management (RCM) program but are not used online by outpatient providers. Consideration is being given to use the CHI with outpatient providers, although this was not in the first year's budget.

**A. Telesage**

DHH/OBH has contracted with Telesage to produce a quality of care state report referred to as TOMS. The report includes five primary performance indicators including: Access to Services, Appropriateness of Services, Medication, Outcome of Services, and Participation in Treatment. Maximum score for each indicator is 3.5 and only participants who completed more than 50% of the questions were included in the calculation. Results for Q2 2012 included:

- Access to Services 3.3 (N=659)
- Appropriateness of Services 3.5 (N=658)
- Medication 3.3 (582)
- Outcome of Services 3.1 (N=645)
- Participation in Treatment 3.5 (N=649).

General Satisfaction Questions (for Q2)

- If you could go anywhere you wanted for services, would you continue to come here? Yes 90.5% (N=652)
- Would you recommend this clinic to a friend or family member? Yes 93.1% (N=652)

Results for Q3 2012 included:

- Access to Services 3.1 (N=262)
- Appropriateness of Services 3.2 (N=261)
- Medication 3.1 (239)
- Outcome of Services 2.9 (N=255)
- Participation in Treatment 3.3 (N=251).

General Satisfaction Questions (for Q3)

- If you could go anywhere you wanted for services, would you continue to come here? Yes 85.3% (N=259)
- Would you recommend this clinic to a friend or family member? Yes 89.2% (N=259)

Magellan has met with DHH/OBH and Telesage to request that TOMS include reports on addiction services provided by DHH/OBH clinics in TOMS (in addition to the report on mental health services). These reports do not include non-DHH/OBH affiliated outpatient clinic treatment providers.

**B.** Magellan has developed Indicators for the Louisiana Coordinated System of Care (see table below). Some of the more notable findings are as follows:

- Average time in days from date of referral to WAA to date FOC is signed - 3.9 days. While this is relatively quick (a goal for this measure has not been established), the sooner the parents sign the Freedom of Choice the more likely it is the family will engage with the WAA. The CSoC team will explore possible barriers that prevent families from signing the FOC sooner.

- The majority of CSoC treatment services are PSR and CPST. Most CSoC children are automatically authorized for Parent Support and Training and Youth Support and Training when enrolling in WAAs.
- For this initial contract year, the CSoC program made 2,016 referrals of children to WAAs based on Comprehensive CANS screening. The total enrollment in WAAs during the year was 1,295. At the end of the contract year, there were 723 CSoC children enrolled with the WAAs. The CSoC program will attempt to interview families who declined services to determine why services were refused.
- The services provided by the WAAs are apparently helping to stabilize these children and their families, since only .3% of the CSoC youth had crisis plans implemented in the contract year.
- 24% of CSoC youth had one inpatient admission, and almost half of these youth (or 12% of the total), had a second readmission. Other data analyses revealed that this readmission rate was significantly lower than the readmission rate for a matched group of youth (those who passed the brief CANS but did not reside in a CSoC implementing region). Thus, the CSoC program appears to be having a significant positive impact on decreasing the risk of inpatient admission.

The following table lists 17 outcome measures to track CSoC program access and outcomes. The target measure outcomes are listed in Appendix C.

| **Target Measure** | **Definitions (Note: CM = care management; IP = Integrated Product; CA = Clinical Advisor)** | **Reporting metric and/or time period** |
|---|---|---|
| 1. Appointment Access/WAA Fidelity<br><br>Result: 3.9 days | Appointment access is defined as the number of days it takes from initial date of authorization for services to the date in which the first billable service is submitted in IP after the FOC is signed.<br>2) The second definition is the time interval between the dates when the brief CANS is passed to the date when the initial referral is made to the WAA.<br>3) The third definition is the time from date of referral to WAA to date FOC is signed. | The mean number of days to first appointment will be calculated as the total number of days from initial date of authorization to date in which the first billable service is submitted divided by the total number of children who have had billable services provided to them. This will be reported on a quarterly basis.<br>2) The mean number of days from the time the brief CANS is passed to the date of initial referral will calculated as the total number of such days divided by the number of children who have been referred for services. This will be reported on a quarterly basis. |
| 2. Emergency | ED utilization is recorded in IP via claims | The percentage will be |

| Target Measure | Definitions (Note: CM = care management; IP = Integrated Product; CA = Clinical Advisor) | Reporting metric and/or time period |
|---|---|---|
| Department (ED) Utilization<br><br>Result: 7% | filed by the ED/hospital with Magellan. | calculated as the number of CSoC youth who have had one or more ED visits divided by the number of CSoC youth. The mean number of ED visits among CSoC children with at least one ED visits can also be reported. This measure will not capture enrollment into the CSoC program from ED's. This will be reported on a quarterly basis. |
| 3. Utilization of Community Resources<br><br>Results:<br>• PSR – 62.7<br>• CPST – 40.2<br>• PST – 13.1<br>• YST – 7.3<br>• MST – 2.7<br>• Respite – 0.03 | The CSoC community-based services are CPST, PSR, Independent Living, Respite, Parent and Youth training, and Case Conference | The mean will be calculated as the total number of community-based services billed divided by the total number of CSoC youth and will be reported on a quarterly basis. |
| 4. Utilization of Wraparound Facilitated Services (as evidenced by):<br>Failure to enroll within ten days of initial referral<br>&<br>Refusal to sign FOC within ten days of initial referral<br>&<br>Length of stay after enrollment<br><br>Results:<br>• Failure to enroll – 15.3%<br>• ALOS – 157 days | Since all CSoC families will have a POC with WAA facilitated services, the interest is in the number of referred families that do not enroll and if enrolled what the average length of stay is after enrollment. | The percentage of referred families that are not enrolled (for reasons a and b) will be calculated as the number of referred families that were not enrolled divided by the number of families that were referred for services. This will be reported on a quarterly basis. Average length of stay after enrollment will also be reported (c). |
| 5. Utilization of Peer Support Services | Peer support services are reported by FSO's and billed as S5110 (Parent Support and Training) or H0038 (Youth support | The mean number of H0038 services provided to CSoC youth will be calculated as the |

| Target Measure | Definitions (Note: CM = care management; IP = Integrated Product; CA = Clinical Advisor) | Reporting metric and/or time period |
|---|---|---|
| Results:<br>• PST – 13.2<br>• YST – 7.3 | and training) in CA. | number of services provided divided by the number of CSoC youth enrolled. The mean number of S5110 services provided to parents will be calculated as the total number of S5110 services provided divided by the number of CSoC enrolled. This will be reported on a quarterly basis. |
| 6. Number of Peer Specialists Providing Services<br><br>Result: 48 | A peer support specialist (parent and/or youth support specialist) is an individual who is so designated by the FSO. The FSO's will report the number of peer support specialists. | The number of full and part-time peer specialists and the number providing services will be reported on a quarterly basis. |
| 7. Number of Wraparound Plans Developed per Youth Served<br><br>Result: 0.97 | If the POC is approved, the agencies are authorized to provide an additional 180 days of service. At the end of this 180 day period, each POC must be re-authorized. The number of plans authorized every 180 days will be reported. These 180 day authorizations are recorded in CA by the provider. | The mean number of POC's developed per youth will be calculated as the total number of plans authorized every 180 days divided by the total number of CSoC youth enrolled. This will be reported on a quarterly basis. Those providers who develop either a very low or a very high number of treatment plans will be identified and will be reviewed |
| 8. Youth Screened, Identified as At-Risk and Referred to Wraparound Agency<br><br>Result: 97.6% | The number of youth screened with the brief CANS and referred to WAAs/FSO's/IA's is captured in IP and or by Magellan CSoC team. | The percentage will be calculated as the number of youth referred to WAAs divided by the number given the brief CANS. This will be reported on a quarterly basis. |
| 9. Crisis plans developed and implemented as part of individualized service plan<br><br>Result: 0.3% | The number of youth with crisis plans who have had their crisis plans implemented because of a crisis will be reported. "Implemented" means that the crisis plan was used to help stabilize the youth during a crisis. These data will be reported by WAAs/FSO's in CA using H0045. This will permit tracking the number of youth who experience crises. The crisis plan implementation will be reviewed during a chart audit of the Wraparound Agency to determine if the | The percentage will be calculated as the number of CSoC youth with crisis plans implemented as measured by H0045 divided by the total number of CSoC youth with crisis plans. This will be reported on a quarterly basis. We will audit charts of youth that have an unusual number of crisis plans implemented (e.g., more than two standard |

| Target Measure | Definitions (Note: CM = care management; IP = Integrated Product; CA = Clinical Advisor) | Reporting metric and/or time period |
|---|---|---|
| | crisis plan was fully implemented using the full range of community resources. | deviations above the mean). A summary of the review of the "fidelity" of the crisis plans implemented will be reported quarterly. |
| 10. Readmissions<br><br>Result: 48% | The re-admission rates to inpatient psychiatric hospitals or facilities. These re-admissions are coded in IP. | The percentage of CSoC youth re-admitted to in-patient facilities will be calculated as the number re-admitted divided by all CSoC youth **with at least one in-patient admission**. The mean number of readmissions among CSoC youth with at least one readmission will also be reported. This will be reported on a quarterly basis. |
| 11. Utilization of claims paid services (annual)<br><br>Results:<br>• PSR – 62.7<br>• CPST – 40.2<br>• PST – 13.1<br>• YST – 7.3<br>• Residential – 4.0<br>•<br>• IP/OP High – 2.5<br>• Med Mngmt – 2.3 | Each claims based service listed below can be tracked by claims and the frequencies of such services can be reported. It is recommended that, at first, the seven most frequently occurring services be reported.<br>Youth Support and Training (YST) (H0038)<br>Parent Support and Training (PST) (S5110)<br>Independent Living (INL) (H2014)<br>Short-term Respite (S5150)<br>Crisis Stabilization (H0045)<br>Crisis Intervention (H2011) and (S9485)<br>Home Builders (H0036 HK, HO)<br>Case Conference (CCO) (99367, 99368)<br>Psychosocial Rehabilitation (PSR) (H2017)Community Psychiatric Support and Treatment (CPST, FFT; Mental Health Programs; Integrated Mental Health and Substance Abuse Programs) (H0036)<br>Addiction Services (H2036, H2034)<br>Hospital (IP, Acute Detox)<br>Psychiatric Residential Treatment Facility (PRTF) (PRT, RSI) (H2013, H0011) TGH (H0018), NMGH (T2048), TFC (S5145).<br>Other Licensed Practitioner<br>Outpatient and inpatient hospital (90801, 90802, 90806 , 90845, 90846, | Average number of visits per enrolled child by type of service |

| Target Measure | Definitions (Note: CM = care management; IP = Integrated Product; CA = Clinical Advisor) | Reporting metric and/or time period |
|---|---|---|
| | 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 90880, 96101, 96105, 96116, 96118, 96150, 96151, 96152, 96153, 96154, 96155, 99201, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99241, 99243, 99242, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99429, 99499, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, J0515, J2680, 90801, 90847, 90849, 90853, 90862, 90889)<br>Medical Physician/Psychiatric Outpatient services (J3490, H0049, H0050, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90812, 90814, 90845, 90846, 90853, 90887, 90857, 90862, 96101, 96102, 96103, 96119, 96118, 96120, 96150, 96151, 96152, 96153, 96154, 96155, 96372<br>WAA community-based services (H2021) | |
| 12. Behavioral health costs<br>Result:<br>**All CsoC:**<br>Average Expenditure per Child (annual) - $2,854.44<br><br>**Average Cost per CsoC child by Level of Care (annual)**<br>Non Medicaid<br>• IOP - $134.03<br>• OP - $262.07<br><br>Medicaid<br>• RTC - $12,792.11<br>• Other - $4,466.21<br>• IP - $5,106.30<br>• IOP - $1,092.07 | Claims services can report the average cost per CSoC child served per month overall and by level of care (LOC codes: 100 = inpatient; 200 = Residential; 400 = IOP; 500 OP; 370 = SA Residential ASAM III.1 HWH; 371= SA Residential ASAM III.2D; 372 = SA Residential ASAM III.3; 373 = SA Residential ASAM III.5; 374 = SA Residential ASAM III.5D (LA only); 375 = SA Residential ASAM III.7; 376 = SA Residential ASAM III.7D). PRTF does not currently have a specific outcome code and outcome code 200 is used at this time. PRTF can be identified by the HCPC service codes along with the specific modifiers. | A mean cost for all CSoC children will be calculated as well as the mean cost for CSoC children by level of care. The mean expenditure per month for all CSoC children will be calculated as the total expenditure divided by the total number of CSoC children. |

| Target Measure | Definitions (Note: CM = care management; IP = Integrated Product; CA = Clinical Advisor) | Reporting metric and/or time period |
|---|---|---|
| • OP - $2,136.12<br><br>**Average expenditure per month all CsoC**<br>Non-Medicaid<br>• IOP - $33.50<br>• OP - $1550.57<br><br>Medicaid<br>• RTC - $15,990.54<br>• Other - $4,838.39<br>• IP - $56,594.80<br>• IOP - $364.02<br>• OP - $180,857.95 | | The mean expenditure by LOC per month will be calculated as the total expenditure for CSoC children in each level of care divided by the number of CSoC children in each relevant level of care. This will be reported on a quarterly basis. |
| 13. School attendance*<br><br>Results:<br>• R1 – 3.53<br>• R2 – 2.55<br>• R3 – 2.20<br>• R4 – 1.42<br><br>*Due to inability to obtain attendance data, calculation is mean days missed (excluding suspensions/expulsions) | The ability to report mean attendance rates depends on the willingness of the DOE to report school attendance for CSoC children. If the DOE does not provide this data, we may be able to get this data from the WAAs and the FSO's (if they are asked to collect this data from the CSoC youth and families). It will not be possible to track attendance across all possible school types and settings. Since not all CSoC children enroll at the same time, it will be difficult to calculate mean attendance rates for CSoC children that were not enrolled at the beginning of the school year. | The mean public school attendance rates will be calculated as the total number of days of school attended divided by the number of CSoC youth who enrolled at the beginning of the school year (excluding excused days). This will be reported on a semi-annual basis by DOE and on a quarterly basis by the WAA. |
| 14. Conduct: Suspensions/ expulsions*<br><br>Results:<br>Suspensions<br>• R1 – 27.0<br>• R2 – 24.0<br>• R3 – 15.0<br>• R4 – 6.0<br><br>Expulsions:<br>• R1 – 5.0<br>• R2 – 7.0 | The number of CSoC youth who have been suspended or expelled (as defined by DOE) in a designated time period (e.g., report card periods) will be reported. Our ability to report suspensions/expulsions depends on the willingness of the DOE to provide this information. If DOE does not provide this information, we should be able to get such information from WAAs and the FSO's. | The percentage of CSoC youth that has been suspended or expelled is defined as the number suspended + expelled (defined by DOE) divided by all current CSoC children. This will be reported on a semi-annually. |

| Target Measure | Definitions (Note: CM = care management; IP = Integrated Product; CA = Clinical Advisor) | Reporting metric and/or time period |
|---|---|---|
| • R3 – 7.0<br>• R4 – 3.0 | | |
| 15. School performance*<br><br>Results:<br>• R1 – 2.30<br>• R2 – 2.29<br>• R3 – 2.14<br>• R4 – 2.08<br><br>*Mean changes in GPA across sequential report cards | Changes in the grade performance of CSoC youth attending DOE public schools, as indicated by changes in grade point averages on report cards, will be reported. We will not be tracking grade data on students in special ed or in alternative school settings since these students may be graded on different scales. The ability to track changes in grade performance of CSoC youth depends on the willingness of the DOE to provide grades. The WAAs are charged with collecting and reporting grades. | We will report the mean change in GPA's across sequential report cards (e.g., mean change across CSoC youth from report card 1 to report card 2; mean change from report card 2 to report card 3; etc.) |
| 16. Decreased number of CSoC youth placed in restrictive settings, including psychiatric inpatient settings*<br><br>Results:<br>• Prior to enrollment – 26.8%<br>• Post enrollment – 13.5% | This variable will start off with a baseline report of the number of CSoC youth currently in restrictive settings. Restrictive settings are defined as any out-of-home placement with the exception of non-therapeutic foster home (by Magellan definition this is not a restrictive setting). Examples include inpatient hospital or substance abuse facility, detention setting, residential treatment facility, therapeutic group home, psychiatric residential treatment facility, half-way house, and therapeutic foster care home. Restrictive setting placement is documented in IP and submitted by WAA. | The number of CSoC youth in restrictive settings will be reported quarterly. The percentage will be calculated as the number of CSoC youth in restrictive settings divided by the total number of all CSoC youth and will be reported quarterly. |
| Items 13-16 | The responsibility is with the WAA to collect the necessary data and forward to Magellan on a monthly basis | |
| 17. Utilization of Natural Supports<br><br>Result: 69% | Presence of natural supports as listed on POCs. Wraparound agencies are charged with collecting and reporting this information. | Reporting measure will be the percentage of POCs that have natural supports implemented |

**C. CHI survey**

The Louisiana CMC uses the CHI assessment in the ICM (RCM) program. In calendar year 2012 there were sixty RCM CHI assessments. Fifty three members completed the intake and 30-day assessment. Of these 53, 19 were female and 34 were male. On the emotional scale, 50% of members with surveys at intake and 30-days had clinically significant improvement in

emotional scores. Those members with surveys at intake and a final administration of the survey had a 25% improvement in emotional health scores. Physical health was included in the survey and members surveyed at intake and 30-days revealed that 50% had a clinically significant improvement in physical health. Seventy-five percent with an initial and final assessment reported satisfaction with the RCM program.

UM plans for use of the CHI for 2013:

- Review the child and adult CHI Training Manual and present the information to the RCM team by end of February.
- Initial surveys to be completed by the RCM Intake Care Manager or a Peer Specialist if member is in a 24 hour facility (i.e., IP or Residential) within Region 2 or 4.
- 30-day and Discharge CHI surveys to be completed primarily by the RCM assigned Care Manager.
- Review all quarterly reports.

**VIII. Treatment Record Reviews**

Existing Magellan TRR instruments were customized for use at the Louisiana CMC. The Outpatient TRR Tool is a Magellan Corporate instrument that was modified to use terms that are familiar in Louisiana. The Inpatient Psychiatric TRR Tool borrows a design from our Maricopa CMC, but has been customized for LA and reviewed against the LBHP Magellan Provider Handbook. In addition, the Residential Substance Abuse TRR Tool was modified to be consistent with DHH licensing standards. The WAA tool is unique to the LBHP and was designed using the LBHP Service Definitions Manual and refined through interviews with CSoC staff.

TRR Tool items are selected to identify documentation of significant clinical processes through in-depth chart reviews. The structure of the TRR tools is designed to follow a logical progression through intake, assessment, treatment planning/plan development, service delivery, and discharge planning. There is emphasis on coordination of care with follow-up providers and inclusion of interdisciplinary and family involvement in client-centered treatment planning.

The Magellan Quality Improvement Review Team consists of 9 QI Clinical Reviewers (7 LMHP's and 2 RN's). Our review team conducts on-site and desktop (mail-in) chart reviews. The general TRR work flow is:

- A primary reviewer is assigned a provider and interviews Magellan Care Managers to identify concerns.
- Contact is established with the appropriate person(s) at the facility/clinic to be reviewed.
- The primary clinical reviewer sends the provider a request identifying a sample of approximately 10-15 cases that have been authorized for services since March 1, 2012. The review tool that will be used to review the cases is provided with the case sample.
- On-site reviews are conducted with a team approach, involving three to five licensed mental health professionals and/or nursing staff conducting reviews of case records.

- Item-by-item scoring is entered in an Excel spreadsheet at the completion of each record review which permits the team to provide a preliminary summary of the findings at the exit interview.
- The review team conducts the exit interview as a collaborative exercise, asking for provider concerns that can be shared with appropriate departments within Magellan. Desktop review, as would be expected, does not permit an exit interview. For all reviews, the reviewer follows up with the provider by phone to discuss the results of the review and answer questions regarding the report.

**Treatment Record Review Reports**

Treatment record reports identify "strengths" and "opportunities for improvement," as well as a percentage score based on number of items compliant out of number of items reviewed. The "opportunities for improvement" suggest specific actions the provider can take to improve service delivery and/or documentation issues. Overall, scores that fall below 80% require an informal corrective action plan (providers specify corrective actions within 30-days of receiving the review report and attest to implementation within 90 days). Scores below 70% require a formal corrective action plan (a follow-up review is conducted approximately 90 days following implementation of corrective actions). The QI Clinical Review Team reserves the option to implement a formal corrective action plan when significant patient safety issues are identified even if the overall review score exceeds 80%.

Review of Inpatient Psychiatric Hospitals began on 6/14/12. Eighty-three providers were reviewed during the 2012 – 2013 contract year. The goal for the contract year 2012-13 was to complete an initial review of all providers who had more than 25 admissions authorized through Magellan. The QI review team met its goal of completing reviews of the top 50 psychiatric inpatient hospitals. A total of 32,331 items in 687 treatment records have been reviewed using the Inpatient Psychiatric TRR Tool.

The Residential Substance Abuse TRR Tool is used to review all levels of residential care from Inpatient Medical Detox through Halfway Houses. By the end of the contract year 2012-13, thirteen facilities were reviewed. The reviews covered 7,929 items in 183 treatment records. The overall compliance score for this level of care was 89%.

Outpatient reviews include traditional outpatient providers as well as mental health rehabilitation agencies. The QI review team completed reviews of 18 facilities and 240 treatment records. The overall score for the outpatient facilities was 70%.

Wraparound Agencies support families and provide individualized case planning for children and adolescents with complex behavioral health needs. These agencies utilize a Coordinated System of Care approach for children in out of home placements or at risk of being placed out of their homes for behavioral health care. At present, one Wraparound Agency has undergone a treatment record review with 142 items in 15 treatment records having been reviewed (by April 2013 reviews of all five WAAs were completed). The overall compliance score for WAAs was 89%.

TRR Summary

- By the end of the contract year, 83 facilities were reviewed by the Magellan QI clinical reviewers. These include inpatient, outpatient, substance abuse, and wrap around agencies.
- The inpatient psychiatric facilities achieved an impressive compliance score of 91% (80% is the minimal pass score).
- Six outpatient facilities were reviewed; 3645 items scored. The overall score for the outpatient facilities was 59.9%. Interventions are planned to provide technical assistance to these facilities for treatment planning and discharge planning.
- Six residential substance abuse facilities have been reviewed with a total of 3833 items scored. Their overall compliance score was 90.2%.
- In the contract year, a review of one wraparound agency was completed; however since April 2013 reviews were completed with all five wraparound agencies. All wraparound agencies were found to be in compliance.

The following table presents the planned TRR activities by level of care for the next three years.

| **Three Year Plan (for facilities with a census of ≥25)** | | | | |
|---|---|---|---|---|
| Level of Care | Year 1 | Year 2 | Year 3 | Total |
| Inpatient | 23 | 23 | 23 | 69 |
| PRTF | 1 | 1 | 1 | |
| Residential | 9 | 9 | 9 | 27 |
| ACT | 7 | 7 | 7 | 10 |
| WAA | 5 | 5 | 5 | 5 |
| Parent/Peer Support | 3 | 2 | 2 | 6 |
| FSO | 1 | 1 | 1 | 1 |
| CPST/PSR/Homebuilders | 55 | 55 | 55 | 165 |
| Outpatient | 33 | 33 | 33 | 99 |
| Total | 136 | 136 | 136 | |

The LA CMC has identified the opportunity to improve its processes surrounding the monitoring of Home and Community-based Services (HCBS) through the 1915 (b), (c), and (i) wavier/amendments. A TRR schedule will be established by the QI department for high volume HCBS providers as part of the three year monitoring plan. A sample of treatment records from each provider will be reviewed against waiver performance measure standards at least once every three years, beginning in the year the provider was first identified as a high volume provider.

The waiver treatment record review will be conducted by the QI department and the Coordinated System of Care department using a Waiver Audit Tool. The audit tool will be used to capture data on all waiver performance measures that require collection by record review. Reviews will be conducted via desktop or onsite depending on the geographic location of the provider. Magellan will use the methodology for sample size and selection as determined by the CMS guidelines. The CMS sample requirements will be met annually and reported on

quarterly to the Interdepartmental Monitoring Team (IMT). Quality standards will be audited simultaneously as part of the quality treatment record review when possible.

The Quality Improvement Committee and the IMT will be responsible for reviewing the results of HCBS waiver audits and the identification, oversight, and follow up of action plans developed as a result of waiver treatment record reviews. Providers who score outside of the minimum performance threshold as defined by the waiver requirements will be required to submit a written corrective action plan of the interventions the provider intends to take to correct the identified deficiencies and the timeline for implementation of the interventions. Technical assistance will be provided to the network by Magellan as indicated.

## IX. Clinical Practice Guidelines

To deliver quality behavioral health care to our members, Magellan adopts, develops, and distributes clinical practice guidelines based on sound scientific evidence, clinical best practices and member needs. The Louisiana CMC has made these guidelines available to all providers via the provider website. Quality of clinical services is assessed by the QI Treatment Record Review team. The Louisiana CMC focused on compliance with the American Psychiatric Association's clinical practice guidelines for the treatment of ADHD, substance use disorders and depression at the outpatient and residential substance abuse levels of care during the 2012 evaluation year. As noted above in the TRR section, the outpatient facilities compliance scores were below the 80% standard. The plan for the 2013 year is to implement trainings for these providers that outline documentation standards for the guidelines. These trainings will be placed on the Louisiana provider website for reference and will include reporting of adverse incidents, discharge planning guidelines, and clinical practice guidelines. Magellan is planning to expand the clinical practice guidelines reviewed to include psychosis.

## X. Prevention Program Activities

The Louisiana CMC has a vested interest in ensuring that its members have access to prevention programs that will help them live healthier lives. To ensure our members can sustain healthy lifestyles mentally, the Louisiana CMC has begun implementation of several initiatives, as well as partnered with other entities.

The Primary Care Physician PIP is a major initiative to prevent or reduce psychiatric hospital readmission rates by increasing the coordination of care across the health spectrum. It is well known that a major predictor of relapse among persons with mental health problems is medication non-compliance. Given the wide spread shortage of psychiatrists, it is clear that an integration of mental health with primary care health is critical to ensure stabilization through medication prescribing and monitoring, and care for co morbid physical health problems. Our initial PCP program has shown promise, and we are continuing to develop this PIP in 2013.

The Birth Outcomes Initiative (BOI) is a collaborative initiative that monitors how and why a high number of births occur before 39 weeks of pregnancy and strives to reduce the number of days babies born in Louisiana spend in neonatal Intensive Care units by 20,000. The Louisiana CMC, along with the March of Dimes and the Louisiana Hospital Association, has taken on an active role in this initiative to assist in decreasing the number of children born addicted to drugs, to help mothers locate resources to curtail their drug use and to improve the overall health and well-being of the mother and child. These initiatives are just additional ways that the Louisiana CMC is seeking to improve the lives of its members.

## XI. Behavioral Continuum and Behavioral/Medical Integration Activities

The Louisiana CMC recognizes the importance of integrating clinical as well as recovery and resiliency services with primary medical care. To achieve these goals, the CMC's Chief Medical Officer directs and implements the annual Medical Integration Plan. Collaboration with the customer organization is maintained throughout this process, from development and implementation through assessment of impact. There is continued emphasis on data collection in multiple areas and collaborative data analysis to identify opportunities for improvement when possible.

Core components of the Louisiana CMC Medical Integration Strategy, include:

- Exchange of information with behavioral health providers, recovery support providers, and with primary care physicians
- Provision of information/education to primary care physicians to promote appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
- Review of pharmacy benefits and formularies
- Ensuring appropriate use of psychopharmacological medications
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
- Tracking of over and under-utilization to ensure equitable distribution of financial resources
- Collaborative development/adoption of prevention programs for BH

Magellan is actively involved with the Bayou Health Plans to improve coordination of care and exchange of information. The CMC Medical Director routinely holds staff rounds with Care Managers on the concurrent review team to review and discuss complex cases, members' medical complications and refer as appropriate to Physician Advisors for additional review and discussion with the attending provider. With member authorization, outreach and communication with the PCP may occur.

Magellan is able to identify the member's Bayou Health Plan through its data systems. This information is communicated to Utilization Review personnel located in inpatient facilities and facility UM personnel are encouraged to work with the member to coordinate with the PCP. Discharge planning and care coordination are also part of the standard Magellan care

management activities. During each concurrent review of an inpatient stay, the Care Manager works with the facility utilization reviewer to shape patient discharge planning through assessment of member needs, inquiring about the discharge plan, linking the inpatient facility to appropriate community based providers, and referral to Magellan follow up specialists to provide additional support, as needed. In addition, Magellan's follow up team is responsible for confirming whether the member kept their appointment.

Magellan's Recovery/Resiliency care management team (RCM) provides care coordination with various community based providers as well as each of the Bayou Health Plans for members with the highest needs. This team focuses on members who have frequent readmissions to higher levels of care and who have various co-morbid conditions. Each of the Bayou Health Plans has an assigned care manager who participates with the health plan in clinical case conferences when the member is served by both Magellan and the health plan.

## XII. Evidence-Based and Best Practice Initiatives

The Louisiana CMC authorizes the following evidence-based practices:

### 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 consumer. The majority of ACT services are provided in the community by multidisciplinary teams. Treatment is person-centered. In the first year, there were 1140 authorizations for ACT services. The mean number of days used in ACT was 163.5. Forty five percent of the members in ACT were male. The most common diagnoses were psychosis and mood disorders.

The primary goals of the ACT program and treatment regimen are to:

- Lessen or eliminate the debilitating symptoms of mental illness each individual consumer 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

**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. Depression and other disorders are considered, as long as the existing mental and BH issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance abuse 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 workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth. There were over 1940 authorizations for MST/FFT in the contract year. The most common diagnosis was Behavior Disorders.

| ACT | Member Region | N | Mean Days Used | Age | Sex | N | Race | N | Primary Dx | N |
|---|---|---|---|---|---|---|---|---|---|---|
| | MHSD | 258 | 177 | 41 | M | 408 | B | 425 | Psychosis | 774 |
| | JPHSD | 221 | | | F | 643 | W | 252 | Mood | 237 |
| | Region 4 | 162 | | | | | ? | 360 | | |
| | CAHSD | 123 | | | | | | | | |
| MST | **Member Region** | **N** | **Mean Days Used** | **Age** | **Sex** | **N** | **Race** | **N** | **Primary Dx** | **N** |
| | Region 7 | 297 | 150 | 14.5 | M | 773 | B | 1069 | Behavior Disorders | 1087 |
| | Region 8 | 277 | | | F | 803 | W | 351 | | |
| | Region 4 | 256 | | | | | ? | 123 | | |

**C. Homebuilders**

Homebuilders is an intensive, in-home program providing cognitive behavioral therapy (CBT) through family therapy and parent training for families with children (birth to 18 years) demonstrating the following characteristics:

- Antisocial behavior and alienation/delinquent beliefs/general delinquency involvement/drug dealing
- Favorable attitudes toward drug use/early onset of alcohol and other drug use, alcohol and/or drug use
- Early onset of aggression and/or violence
- Victimization and exposure to violence

The primary intervention components of the Homebuilders model are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals, using evidence-based cognitive/behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. Homebuilders programs have been successfully implemented in diverse and multi-ethnic/multicultural communities across the United States and other countries. It is difficult to determine the number of authorizations for homebuilder's services since it is bundled with Community Support Services.

**D. Functional Family Therapy (FFT):**

Functional Family Therapy (FFT) is an evidenced base family intervention for youth with "acting-out" problems (e.g., oppositional defiant disorder, disruptive behavior disorder, ADHD, conduct disorder, and/or disruptive behaviors due to substance abuse). A major goal of Functional Family Therapy is to improve family communication by decreasing family discord. Another goal is to teach families methods of positive problem solving. Although originally designed to treat middle class families with delinquent and pre-delinquent youth, the program has recently included poor, multi-ethnic, multi-cultural populations, with very serious problems such as conduct disorder, adolescent drug abuse, and violence. The program is conducted by family therapists working with each individual family in a clinical setting, which is standard for most family therapy programs. FFT has demonstrated the ability to reduce youth prison recidivism rates when compared to alternative treatments and no treatment conditions. The provider agency must have a current license issued by the DHH. Youth with substance abuse issues may be included if they meet the eligibility criteria and FFT is deemed clinically more appropriate than focused drug and alcohol treatment. There were over 1,940 authorizations for MST/FFT in the contract year.

## XIII. Patient Safety

The Magellan LA CMC conducts a wide variety of activities to address the on-going monitoring and improvement of patient safety. The CMC has established routine processes and procedures in addition to targeted activities directed at specific components of mental health treatment. Selected activities have demonstrated improvements related to the care and safety of the members served as discussed below and in other sections of this evaluation.

LA CMC representatives participate in the national Patient Safety Work Group which oversees Magellan's practices and monitoring related to patient safety issues and implements interventions for improvement for targeted measures. Patient Safety issues are also addressed through the standing committees at the LA CMC.

Routine activities conducted from March 1, 2012 to February 28, 2013 to address patient safety include:

- Triage and referral, pre-authorization, concurrent review of treatment services and appropriate service and care based on UM decision criteria. Qualified staff review

member needs and monitor inpatient/outpatient care to help ensure the member receives appropriate care in the least restrictive setting.

- The Recovery Care Management (RCM) Program identifies members with severe problems and provides intensive, coordinated treatment directed at these high-risk members to assist the member to achieve, consolidate and maintain treatment gains. Using the specified criteria list, members who qualify for RCM are identified to the Care Managers and contacted to determine if he/she is willing to participate in the program. If the member agrees to participate, the assigned Care Manager works intensively with him/her to develop a plan with specific goals and interventions. Frequent contact is maintained with the member until RCM goals are met or he/she decides to terminate participation.
- Member Complaints/Grievances: Complaints/grievances are reviewed and responded to at the time of submission. Once the member's issue has been addressed, complaints/grievances identified as possible quality of care concerns are submitted to the Clinical Reviewer responsible for coordinating investigation of quality of care concerns and adverse incidents. The Clinical Reviewer collaborates with the Medical Director to review issues submitted. Based on the results of this review, treatment records may be requested for additional evaluation and follow-up. Customer grievances are also analyzed in aggregate in order to identify trends and opportunities for improvement. Magellan has developed standards and monitors the timeliness of its grievance resolution process.
- Adverse Incidents are reported as soon as a LA CMC staff member is made aware of the incident. All adverse incidents require investigation to determine whether there were any quality of care concerns that may have impacted the incident and for which further action is required.
- Provider Inquiry and Review is conducted when a potential quality of care issue has been identified for a specific practitioner or provider. These reviews are completed through the Regional Network Credentialing Committee (RNCC) activities. The RNCC also tracks and trends potential quality of care issues by provider to identify opportunities for improvement.
- Service Authority Criteria are reviewed annually to identify opportunities for updating with recommendations submitted to the State for consideration.
- Quality of Care (QOC) concerns may be submitted by LA CMC staff, facilities or practitioners. All QOC concerns are reviewed by the clinical reviewer in collaboration with the medical director, as needed. If the concern is determined to require investigation, it is investigated and presented to the RNCC for review and recommendations. A summary of QOC activities is also presented to the Quality Improvement Committee (QIC) at least quarterly.
- Credentialing and re-credentialing activities are directed at maintaining a practitioner and provider panel that meets accepted standards of practice. Site visits are conducted based on specified criteria or identification of concerns, to ensure office site and medical record keeping practices are compliant with accreditation and MBHO criteria.
- Treatment record reviews are conducted annually to monitor practitioner treatment record keeping practices and identify areas for improvement in order to promote and maintain safe practices.

- Compliance with at least two components of two guidelines is measured annually. The audit identifies opportunities for improvement and feedback is provided to assist practitioners in identification and implementation of safer practices in care and treatment of patients.
- Magellan creates access standards and monitors service against them so that members are seen within appropriate time standards based on the level of urgency of the case (emergency, urgent, or routine).
- Magellan provides 24 hour, 7-days a week telephonic access to our members to provide information on access to treatment and to promptly address emergencies.
- The LA CMC follows policy and implements best practices designed to connect members discharged from hospitals with outpatient services within 7-days of discharge. Research indicates that success in ensuring timely after-care reduces the probability that a member will require re-admission to a hospital.
- The LA CMC closely audits the actual reviews and decisions completed by Care Managers as well as the quality of their documentation for consistency and compliance with the State established Medical Necessity Criteria. In addition, the LA CMC conducts inter-rater reliability audits at least annually to ensure consistency of decision making.
- The LA CMC follows policies and procedures to facilitate a smooth transition for the member when his/her health coverage changes and his/her previous provider are not in the Magellan network. Abrupt termination with providers or breaks in treatment can often leave the member feeling abandoned and vulnerable, possibly increasing the potential of risk to his/herself or others.
- The LA CMC encourages providers to communicate treatment and medication information with the member's Primary Care Physician for treatment continuity and to avoid potential negative medication interactions. This expectation is communicated through trainings conducted with inpatient facilities, the treatment record review process and feedback, and by encouraging members to allow communication between practitioners.
- Magellan makes available the Magellan Statement on Seclusion and Restraints to practitioners for use.

The measurement results for the routine activities discussed above are presented in other sections of this evaluation. The results are reviewed in the LA CMC QIC as well in customer specific QICs. The results are tracked and trended and opportunities for improvement are analyzed. The table below presents the quantity of selected patient safety monitors conducted during 2012.

| Safety Measure | Outcomes 3/1/2012 – 2/28/2013 |
|---|---|
| Adverse Incident | 52 adverse incidents were reported. All incidents were investigated with appropriate follow-up completed. Follow-up may have included corrective action plan, recommended changes in policies or procedures, education of providers or |

| Safety Measure | Outcomes<br>3/1/2012 – 2/28/2013 |
|---|---|
| | facilities, ongoing monitoring until identified issues are resolved, or removal from the network as warranted. |
| Quality of Care Concerns | 266 Quality of Care concerns were identified. Each QOC was reviewed by the Clinical Reviewer in collaboration with the medical director, if appropriate, and investigated, if recommended. Each QOC is tracked to the specific provider or facility and trends over time are monitored for additional action as needed. |
| Complaint/Grievance review and analysis | There were 39 complaints/grievances. Each was reviewed, addressed, then tracked and trended to identify potential opportunities for improvement. If a potential quality of care concern was identified, the complaint was referred to the Clinical Reviewer for review and determination of next steps. |
| Continuity of Care | There were 26 provider terminations. None were due to quality of care concerns, but 12 were considered "for cause" due to provider not completing recredentialing application and/or failing to return the Medicaid Disclosure Form. Once a provider terminates, members in care are identified and assisted with transition of care to another provider in the area. The CMC process is to notify members at least 30-days prior to the effective termination date to allow for transition of care. Members requiring assistance with arranging services are directed to call the LA CMC for assistance. |

Specific activities undertaken to monitor and improve member safety include:

- QI staff participation on the national Patient Safety Workgroup, which conducted the annual patient safety survey. The survey was expanded to include both practitioners and facilities with revised questions regarding coordination/transition of care, electronic medical records, seclusion and restraints, risk assessment and medication management. See the Patient Safety Survey QIA in section V for further information. Additionally, the

workgroup worked to build safety reporting mechanisms into the new programs identified as national initiatives.

- The LA CMC focused on several issues affecting continuity and coordination of care, thereby working to improve member safety. topics addressed included:
    - Improving provider/member collaboration
    - Promoting practitioner knowledge and use of medications to prevent substance use relapse
    - Ambulatory follow-up after hospitalization
    - Monitoring and promoting appropriate assessment for Suicide Risk
    - Improving coordination of care between BH providers and PCPs

**Recommendations for 2013:**

- Continue routine activities as described above and report through the appropriate committees to the QIC.
- Coordinate with Magellan national staff to distribute Patient Safety Program Survey results for Louisiana to the appropriate LA CMC committees and develop interventions directed at improvement.
- Focus CMC specific initiatives to support improvement of Patient Safety Survey results toward improved coordination of care with PCP and medication management
- Implement distribution of the Suicide Assessment Tool to BH practitioners and PCPs

## XIV. Coordination of Care Activities

The Care Management team has made it a priority to reach out to the physical health plans responsible for caring for Louisiana's Medicaid population, to ensure our members are receiving the necessary care to support their mental and physical health. To that end, the Louisiana CMC Care Management team has instituted monthly meetings with the five health plans that comprise the Bayou Health, which are AmeriGroup, Community Health Solutions, LaCare, Louisiana Healthcare Connections, and United Healthcare Community Plan. These monthly meetings allow the health plans and the Louisiana CMC to exchange information, discuss the needs of members who are jointly managed and to strategize then implement interventions to manage difficult and complex cases.

Two Recovery and Resiliency Care Management (RCM) care managers are assigned to work with the five Bayou Health Plans (BHP) to ensure continuous care is provided to members. The Louisiana CMC care managers and chief medical officer (CMO) attend monthly rounds with the plans. The CMO is also available for further consultation, when needed.

The Louisiana CMC developed a standard referral form that is used to refer its behavioral health members to a Bayou Health Plan. This form helps bridge the gap between the Louisiana CMC and the Bayou Health Plan and allows one entity to inform the other if it believes a medical health issue is preventing or undermining the member's sustained behavioral health or physical health. Triggers for a referral to the Louisiana CMC include:

1) The number of inpatient admissions,
2) A child under the age of 12 admitted inpatient,
3) A pregnant woman who is also a substance abuser,
4) A child of any age with one inpatient admission and a diagnosis of autism spectrum disorder,
5) A member with 2 or more inpatient psychiatric stays within a rolling 12-month period,
6) A referral from a care manager as a result of a targeted risk assessment, or
7) Other customer specific identifier.

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

The table below presents the referrals received by health plan, number enrolled, and number discharged.

| Bayou Health Plan | # of Referrals to RCM | # Enrolled in RCM | # Discharged from RCM |
|---|---|---|---|
| **AmeriGroup** | 15 | 11 | 0 |
| **LA Healthcare Connections** | 18 | 5 | 0 |
| **Community Health Solutions** | 7 | 4 | 0 |
| **LaCare** | 4 | 2 | 0 |
| **United Healthcare** | 36 | 22 | 2 |
| **Total** | **80** | **44** | **2** |

This collaboration has enabled the Louisiana CMC to monitor the care of its members across the health care delivery spectrum and helped to improve the quality of care members receive.

**Coordinated System of Care (CSoC)**
The children's CSoC is a new initiative of Governor Bobby Jindal, designed for a population of focus comprised of Louisiana's children and youth with significant behavioral health (BH) challenges or co-occurring disorders who are at risk for out-of-home placement. The CSoC provides an evidence-based approach that is part of a national movement to develop family and youth-driven care to keep children at home, in school, and out of the child welfare and juvenile justice systems. Louisiana's CSoC program is innovative because it integrates resources from all the State's child-serving agencies to establish a coordinated system of care, while assuring payment from the appropriate funding source through Magellan.

The primary goals of the CSoC program include:

1. Reducing out of home placements
2. Improving access to care in a cost efficient manner, and

3. Improving outcomes (e.g., educational performance, reduced contacts with juvenile justice programs).

From March 1, 2012 to February 28, 2013, the CSoC program served approximately 1,673 individuals.

46% of enrolled children were male and 52% were female. Of those reporting, approximately 49% were African American and 25% were Caucasian. 2% of the CSoC children were five or younger and 86% were between the ages of 15 and 18. The mean age of children enrolled was 13.37. The four most frequent referral sources for the CSoC program were, in order, family, emergency department, school, and child and youth services (although an admission driver was not present for 43% of the children). The mean length of stay for the 786 children in the CSoC program who were discharged in the first year was 65.23 days. 42% of those children discharged were discharged with 30-days of enrollment, indicating an opportunity exists to improve initiation, engagement, and retention among CSoC children. The two most frequent psychiatric diagnoses among the CSoC children were Disruptive Behavior Disorders (44.6%), which includes ADHD, ODD and Conduct Disorder, and Mood Disorders (33.1%). These two diagnoses accounted for 77% of all diagnoses among CSoC children.

The CSoC provider network remains under development and a significant opportunity noted is the need to add Crisis Stabilization services. Network development is currently underway to address this need.

A total of 6,665 services authorizations were completed during the reporting year. As the table below reveals, CSoC children received authorizations for a wide variety of services, the most frequent of which were Youth Support and Training, and Parent Support and Training (in addition to WAA). While approximately 96% of CSoC children received authorizations for additional services, only 43% actually received these services. Though this finding may be impacted somewhat by provider claims filing and run out, Magellan intends to continue a Performance Improvement Project (PIP) to identify barriers to receipt of services and development of interventions to improve the percent of services actually received. One barrier noted is the fact that selected services, such as Crisis Services and Skills Trainings have few providers in the network. Efforts to recruit such providers are in process.

| CSoC Services | # of Authorizations |
|---|---|
| Youth Support and Training | 1,264 |
| Parent Support and Training | 1,257 |
| Supportive Wrap Around Behavioral Health Services | 1,144 |
| Community Support Services | 907 |
| Psych Rehab | 834 |
| Inpatient, Psychiatric | 671 |
| Outpatient | 251 |
| Supervised House/Living | 59 |
| Residential Treatment | 54 |

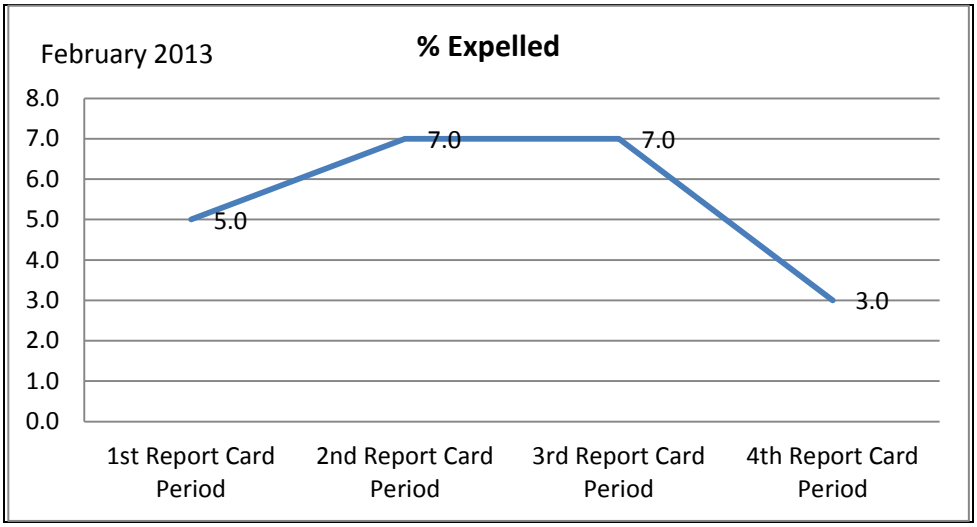
| CSoC Services | # of Authorizations |
|---|---|
| Respite Care | 54 |
| Multisystemic Therapy for Juveniles | 53 |
| Therapeutic Foster Care | 27 |
| Substance Abuse Residential | 24 |
| Intensive Outpatient Treatment | 19 |
| Skills Train & Dev-Group/Family | 18 |
| PRTF (Psychiatric Residential Treatment) | 14 |
| Crisis Services/Stabilization | 12 |
| Group Home | 2 |
| Inpatient, Detoxification | 1 |
| **Total** | **6,665** |

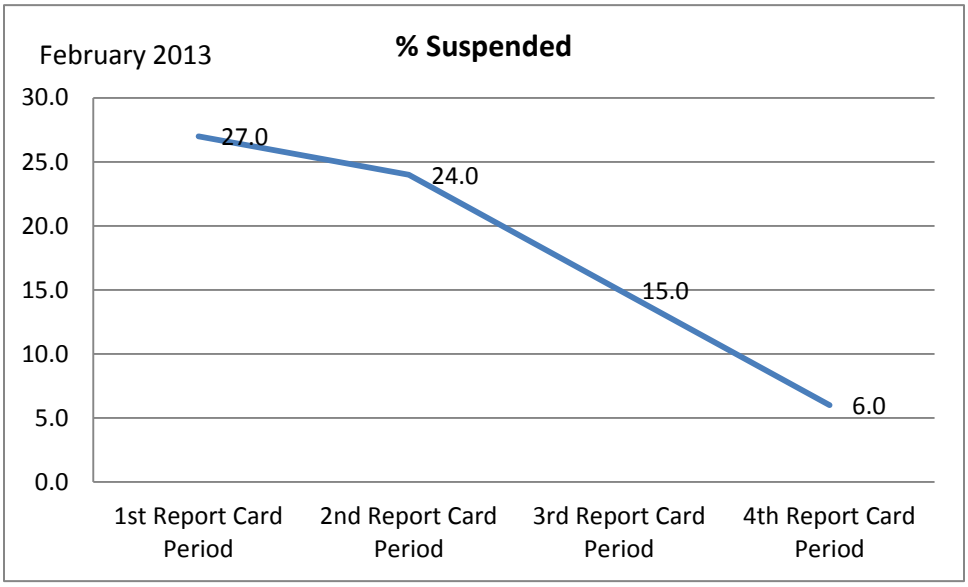
To assess the effectiveness of the program in reducing out of home placements, Magellan compared the CSoC children to a group of children who passed the brief CANS but were not enrolled in CSoC because they were from non-implementing regions. Among the CSoC children, 15.8% experienced an out of home placement across all treatment episodes, while among the matched non-CSoC children, 60.5% experienced an out of home placement across all treatment episodes. Firm conclusions cannot be reached about the effectiveness of the CSoC program in reducing out of home placements since the two groups of children were not matched a priori, although the results tentatively suggest the CSoC program may have reduced out of home placements.

The table below presents educational data, obtained from the WAAs and not from the school system. This data needs to be interpreted cautiously since report card periods are not standardized across school systems and full report card period data cannot be obtained until the end of the full school year. At the time this report was written, Magellan had data on the first three report card periods. As the table shows, the mean GPA across the three report card periods was essentially stable, which may be considered a success for a group of children at risk of failing to attend school.

| Grade Point by Report Card Period | | |
|---|---|---|
| 1st | **2nd** | **3rd** |
| 2.3 (n = 284) | 2.3 (n = 248) | 2.2 (n = 308) |

The premise that the stable GPA results may have reflected decreased absence from school received mixed support based on the expulsion data and stronger support from the suspension data (which demonstrated a steady decline) depicted in the following two tables.




As previously noted, this data demonstrates potentially positive trends due to treatment through the CSoC program.

## XV. Inter-rater Reliability

Magellan clinical policy provides for annual measurement of the consistency of application of medical necessity criteria by clinical care management staff, physician advisor consultants and medical directors. These clinicians across the company are asked to review an identical series of ten (10) vignettes and select the appropriate clinical determination for the level of care by applying the Medical Necessity Criteria (MNC) employed by clinicians at the CMC. The measurement process is designed to conform to customer, NCQA, URAC, and licensing requirements. Answers are scored and reports generated for each individual who participated in the IRR measurement.

All individual reports are reviewed by the clinician's direct supervisor and provided to the individual. The threshold for performance is 9 out of 10 correct answers, and those who responded with fewer than 9 correct answers are asked to participate in educational interventions and re-measurement. If an individual is unable to record 9 correct answers with re-measurement, the supervisor initiates additional interventions to address the clinician's application of criteria.

Magellan initiated procedures regarding monitoring of Physician Advisors beginning first quarter 2013. All physician advisors (PA) who conduct reviews completed the IRR process. The Chief Medical Officer has discussed the results of the testing with each physician advisor. Those who did not achieve at least 90% on the post-test will retake the IRR test in June. Concerns were noted regarding selected IRR questions that referred to levels of care not managed by the Louisiana CMC. It was further noted that the Louisiana Medicaid Service Authorization Criteria vary from the specific test-based criteria used by most Magellan physician advisors who conduct reviews for Magellan's commercial accounts. Quarterly monitoring by the Chief Medical Officer of physician advisors determinations will be implemented to strengthen the national process already in place.

In addition, for those Clinical Reviewers conducting Treatment Records Reviews (TRR), inter-rater reliability is overseen and monitored by the QI Manager. Inter-rater reliability testing was conducted with all Clinical Review staff that complete record reviews. All Clinical Reviewers scored two identical records to determine level of compliance with identified standards and the consistency of reviewer determinations. Findings showed 100% agreement among reviewers regarding whether the records fell into an acceptable or a non-acceptable range of compliance. Selected elements showed some variation and monitoring will be continued toward closing discrepancies in results to the extent possible. This remains a dynamic process and will continue to be monitored quarterly throughout the year.

## XVI. Satisfaction Surveys and Complaints

### Member Satisfaction

Consumer satisfaction surveys remain the most direct measure of assessing the consumer's perceptions of quality and outcome of care. To increase the number of individuals contacted as part of the annual survey, all clients who requested treatment between 01/01/2013 and 03/31/2013 were selected for the sample.

Magellan utilizes a mail-out and mail-back method for collecting the client's perceptions of the quality of care and services received. The first mailing includes the cover letter prepackaged with the client satisfaction questionnaire, and a business reply envelope. Approximately 21 days after the first mailing, a second mailing with a follow-up letter along with another client satisfaction questionnaire and a business reply envelope is sent to those clients who have not yet responded with a completed questionnaire. The survey response period is closed approximately 30-days after the second mailing. Once the surveys are returned to Magellan, they are processed by the Survey Operations department and the report is prepared.

The LA CMC started managing the Louisiana Medicaid population March 1, 2012. This survey provides baseline data for the first year of implementation, from which to identify opportunities and interventions going forward. The survey is based on the Mental Health Statistics Improvement Program (MHSIP) Consumer survey. This survey has been developed at a national level in part to promulgate data standards that allow for valid results to better inform policy and decisions. The survey responses are based on a balanced scale with a neutral middle for most questions. The survey design was modified to better address the public sector and to promote consistency with surveys administered company-wide for the Medicaid population. Survey results were received on June 13, 2013.

| **Overall Satisfaction**<br>**Goal – 80%** | **LA Medicaid Minors** | **LA Medicaid Adults** | **Magellan Aggregate Minors** | **Magellan Aggregate Adults** |
|---|---|---|---|---|
| **Goal – 80% per element** | **2013**<br>**N= 295** | **2013**<br>**N= 297** | **2012**<br>**N=3,620** | **2012**<br>**N=4,173** |
| If you contacted Magellan, how satisfied are you with the help you got to connect with the services you received? | 83.0% | 77.4% | 79.4% | 79.3% |
| I liked the services I/my child received | 87.9% | 81.7% | 84.6% | 86.3% |
| If I had other choices, I would still get services from this agency. | 83.6% | 80.0% | 78.9% | 81.9% |
| Staff members were willing to see me as often as I felt was necessary. | 87.0% | 79.7% | 81.6% | 82.6% |
| Staff members returned my call(s) in 24 hours. | 83.0% | 71.4% | 81.0% | 78.0% |
| The time I waited between appointments was acceptable. | 81.5% | 79.7% | 83.1% | 82.8% |
| Got as much help as needed (child)/<br>Helped connect to services needed (adult) | 81.1% | 79.4% | 74.7% | 80.0% |
| Was able to see a psychiatrist when he/she wanted to | 72.9% | 75.1% | 71.0% | 76.0% |
| Felt comfortable asking questions about my/child's treatment and medication. | 91.2% | 87.3% | 88.4% | 87.2% |
| I was given information about my rights. | 92.2% | 85.1% | 90.2% | 86.1% |
| Overall, your satisfaction with the services and treatment you received. | 85.4% | 79.7% | 85.0% | 88.1% |

Results for selected elements are presented in the table above. As can be seen, the LA Medicaid member satisfaction results are fairly consistent with those seen in aggregate across Magellan public sector populations. The most significant difference is seen with overall satisfaction for the adult population. The Magellan national result is 8.4 percentage points above that seen in Louisiana, though the Louisiana members' overall satisfaction for both minor and adult members meets or exceeds the threshold goal of 80%. The LA CMC has established a member satisfaction survey workgroup to address review results for each element of the survey and develop an action plan to for those elements falling below the established threshold goal.

**Provider Satisfaction**

Provider satisfaction surveys remain the most direct measure of assessing the practitioner's satisfaction with features and services provided by Magellan Health Services. All participating providers who received at least one authorization or submitted a claim for service between March 1 and June 30, 2012 were selected to receive a questionnaire. An additional survey was administered to all participating providers who received at least one authorization or submitted a claim for service between July 1 and December 31, 2012 and providers in the March 1 through June 30, 2012 sample that did not respond to the initial survey administration. Providers' contact information was drawn from Magellan's Integrated Provider Database (IPD).

The questionnaires were distributed by e-mail or postal mail with an option to return them by mail, fax and instructions for completion online. The mailings included a cover letter, a questionnaire and as appropriate a business reply mail envelope. Approximately twenty-one days following the first mailings a second mailing, by postal mail only, was sent to providers who had not returned a questionnaire. 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 approximately 30-days after the second mailing.

The methodology for the Magellan network provider survey is a balanced 4-point Likert scale with two positives and two negative responses. Areas covered by the survey include the overall level of satisfaction of administrative services, care management, utilization management, claims payment, and communication. The survey is composed of 37 items. Twenty-seven items are rated on the variable Likert scale. Additional questions capture information related to demographics and PCP communication. The following table presents the aggregate results for selected elements on this initial survey of Magellan of Louisiana's provider network for the Medicaid population.

| **Key Findings of Aggregate LA CMC and Magellan National Provider Satisfaction Survey 2012** | | |
|---|---|---|
| **Overall Satisfaction Goal – 75%** | **LA CMC N= 138** | **Magellan National N= 8740** |
| **Goal per element – 75%** | **2012** | **2012** |
| Overall satisfaction with Magellan | 80.2% | 90.0% |
| Timeliness of communicating authorization decisions to you | 74.5% | 87.6% |
| Timeliness of claims payments | 77.5% | 88.1% |
| Satisfaction with Magellan regarding credentialing and contracting | 80.2% | 90.6% |
| Satisfaction with Magellan regarding complaint processing | 62.1% | 71.6% |
| Satisfaction with electronic claim submission with Magellan | 85.8% | 87.6% |

As results in the table above show, there are opportunities for improvement in provider satisfaction for the Medicaid provider network. Managed care is new to this market and the results are lower than those seen across Magellan as a whole. The LA CMC results above represent the aggregation of the first and second survey administrations. In comparing the satisfaction results from the initial survey administration to the second survey administration, demonstrable improvement was seen in multiple elements. However, the CMC elected to use the aggregate findings to develop its action plan and identify interventions to address. The LA CMC Member/Practitioner Satisfaction Workgroup reviewed all elements scoring less than 75% and determined go forward activities to promote improvement, as appropriate. The detailed action plan is planned for presentation during the June meeting of the Quality Improvement Committee.

A brief comparison of selected elements from each administration of the survey is summarized below.

**First Administration Period**

The satisfaction rate seen for the first administration period was 74.4%. The three questions with the highest satisfaction ratings were: 1) If you have a client(s) in resiliency care management, how satisfied are you with the overall program and the coordination of your clients' care (100%); 2) Satisfaction with Magellan's language assistance service (i.e., interpretation, translation services) (100%); and 3) Overall satisfaction with MagellanHealth.com/provider website (92.5%). The four lowest satisfaction scores were for the following questions: 1) Clinical appeals process (55.6%); 2) Clinical appeals timeliness (55.6%); 3) Complaint process (50%); and 4) Claims appeals process (55%)**.**

To address these issues, the following interventions were initiated:

- Audit of 100% of appeal case records and timeliness using URAC standards.
- Implemented real time monitoring of letters acknowledging the receipt of the appeal request, and the notice of appeal notice of resolution.
- Completed process maps for all related workflows.
- Revised the appeal denial letter resolution verbiage; added information for Facility/Provider regarding the right to a State Fair Hearing and Request for State Fair Hearing Form.
- Implemented date and time stamp for provider written correspondence requesting appeals.
- Initiated monthly monitoring of turn around time (TAT) and number of days for resolution.
- Implemented real time monitoring of letters acknowledging the receipt of the appeal request, and the notice of appeal notice of resolution.
- Initiated a Provider Dispute appeal as a courtesy that does not require a member's consent.
- Implemented use of Comment and Resolution Tracking (CART)

**Second Administration Period**
There were clear benefits from the interventions implemented after the first administration period. The overall satisfaction rate improved from 74.4% to 83.1% resulting in an overall average satisfaction for both periods of 80.2%, which exceeded the goal of 75%. Other elements saw similar, if less impressive improvement.

A review of the aggregate satisfaction rates per question produced several potential actions/interventions. Interventions to address specific opportunities include:

- **Q5: Consistency of decisions by clinical staff** – Interventions include training staff on authorization criteria, enhanced monitoring through Qfiniti (phone and computer monitoring), as well as completion of inter-rater reliability testing and follow-up.
- **Q10c: Clinical Appeals/Timeliness process** – Clinical appeals process interventions include additional staff training and access to a claims' resolution expert to support processes to meet timelines.
- **Q12: If you have called or written to file a formal complaint, satisfaction with the ease and timeliness of Magellan's complaint resolution process** – Additional staff trainings on how to recognize a complaint, the need to enter complaints into the CART system (internal complaints tracking system), and how to support resolution of provider concerns.
- **Q26: Do you have all of your new patients sign a consent form regarding contact with their primary care physician (PCP)?** Initiation of a performance improvement project directed at increasing coordination of care with PCPs; completion of trainings with six of our largest psychiatric inpatient providers, and promotion of PCP communication through treatment record review processes; improvement in coordination of care rates with PCPs has been seen.

**<u>Complaints/Grievance Analysis</u>**

The Louisiana CMC began capturing customer comments in March 2012. Both provider complaints and member grievances are captured in Magellan's Comment and Resolution Tracking (CART) system. All 129 (100%) complaints and grievances received were resolved within the required CMC standard timeframe of 30-days. 10% of all captured complaints and grievances were resolved during the initial call with Magellan staff.

39 grievances were received from members. The top complaint category related to member dissatisfaction with the quality of care/quality of service of their provider. This category accounted for 82% of all member complaints. The second most frequent reason category accounted for 8% of all grievances and involved varying concerns related to the Care Management department processes. 3% of member grievances involved the receipt of incorrect information from Magellan staff. The average resolution time for member complaints was 17-days.

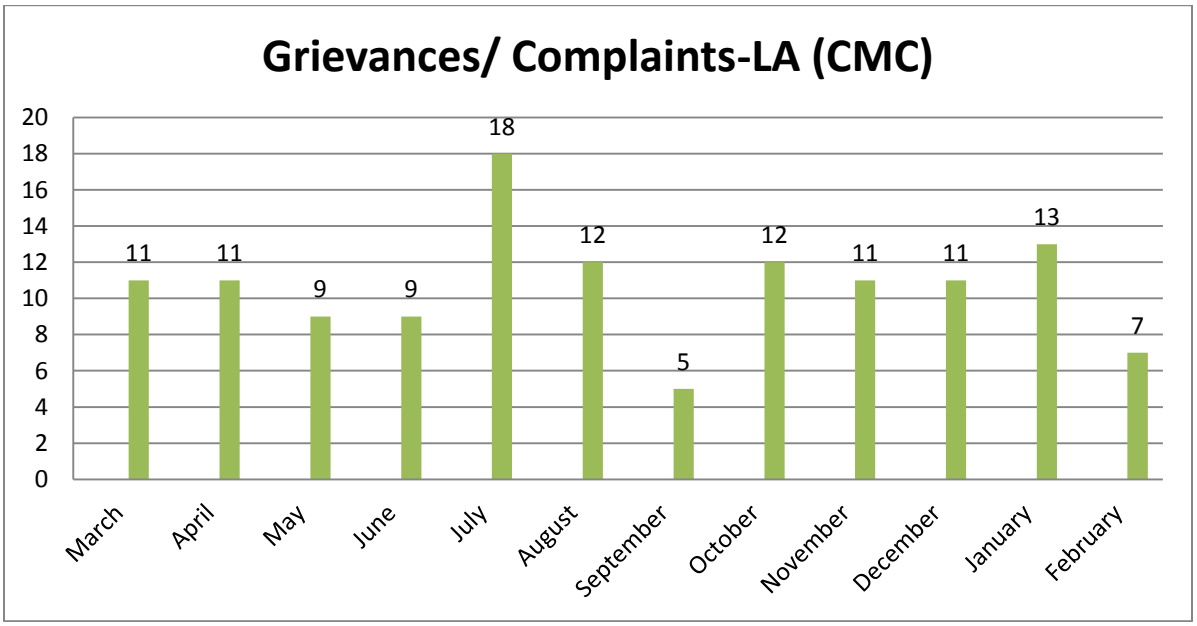
Member grievances filed during the year involved several different population groups. The populations that registered the most grievances were the Medicaid EPSDT+OBH and Medicaid

EPSDT (MH/SA) with grievance rates of 21% and 15% respectively. The Medicaid Adult (MH/SA)/ (1915i) population accounted for 13% of all grievances. The Medicaid Adult (MH/SA), and Medicaid Adult (MH/SA)/ (1915i) +OBH/LGE populations accounted for 10% of all grievances. Medicaid Adult (MH/SA) +OBH/LGE and OBH/LGE (NMCD) ADULT MH+AD SERV accounted for 8%. The remaining populations, Medicaid EPSDT+(IEP)+OBH, Medicaid EPSDT+1915B3, MCAID EPSDT+SPECIAL ED (IEP), MCAID ADULT (MH/SA)+DCFS – FS, accounted for very few of the grievances filed in the 2012 calendar year.

Provider complaint reasons encompassed multiple operational areas of the CMC during the evaluation year. The top comment category for provider complaints involved the Care Management Department (25/90). Comments involving the Care Management Department accounted for 28% of all provider complaints. 21% percent of provider complaints involved claims issues or disputes. 14% dealt with quality of service issues related to Magellan services. The remainder spanned a range of issues. Complaints about access to Magellan's service and receipt of accurate information were relatively low and accounted for only 4% of all provider complaints.

The Grievance and Appeals Department for the Louisiana CMC identified an issue with under-reporting of customer complaints. One barrier to reporting complaints is believed to be the lack of understanding of the complaint capturing process among staff. To that end, a complaint training series has been developed and a refresher training is planned with all staff.

Complaints data is planned for presentation and discussion on a quarterly basis at the Quality Improvement Committee, Member Services Committee, and the Utilization Management Committee meetings. By analyzing this information on a quarterly basis, the CMC should be able to better identify developing trends and respond to issues within appropriate timeframes. A cross-section of Magellan staff will be convened to analyze complaints trends and develop improvement initiatives to address the identified issues during the year.



The graph above is a representation of all grievances received at the LA CMC between March 1, 2012 and February 28, 2013. To date, that number remains low. However, several measures are being taken to ensure that members are aware of their right to file a grievance. Also, staff trainings are taking place to ensure that staff is aware of the CART tracking system and are familiar with how to log grievances.

## XVII. Appeals Analysis

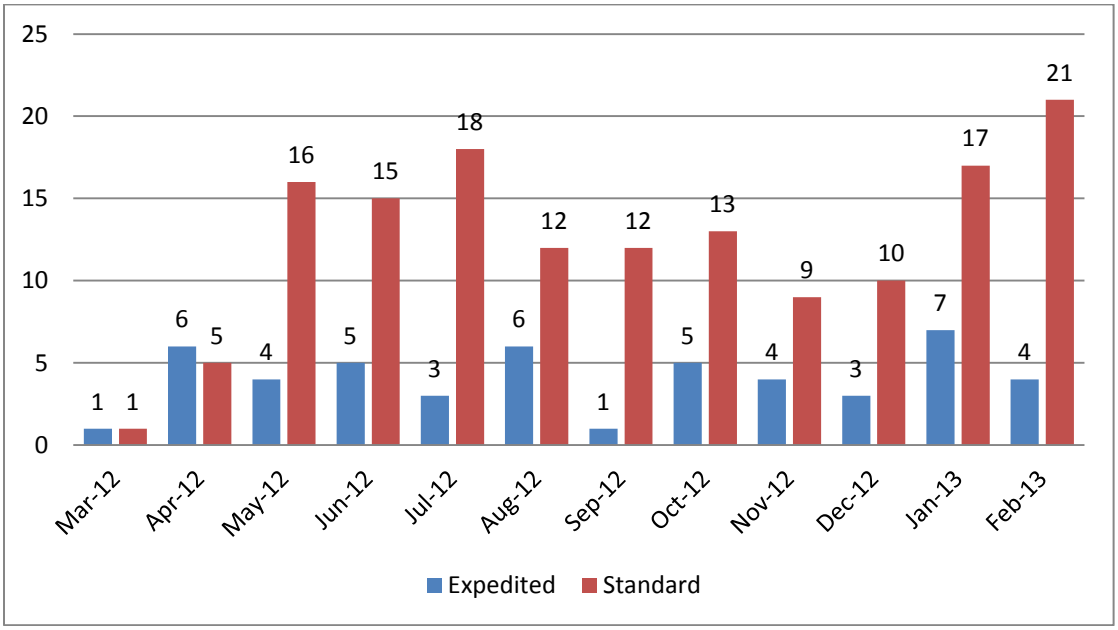
The Louisiana CMC received its first member appeals toward the end of the first quarter post implementation. Member appeals may be filed by a member or by a member's authorized representative, whereas providers may files appeals (provider disputes) on their own behalf. From March 1, 2012 to February 28, 2013, a total of 322 appeals were filed. Member appeals accounted for 198 of those appeals, with providers actually filing a majority of those appeals on the member's behalf.

The Louisiana CMC began handling provider disputes in October 2012. Provider disputes accounted for 124 of the total appeals filed.

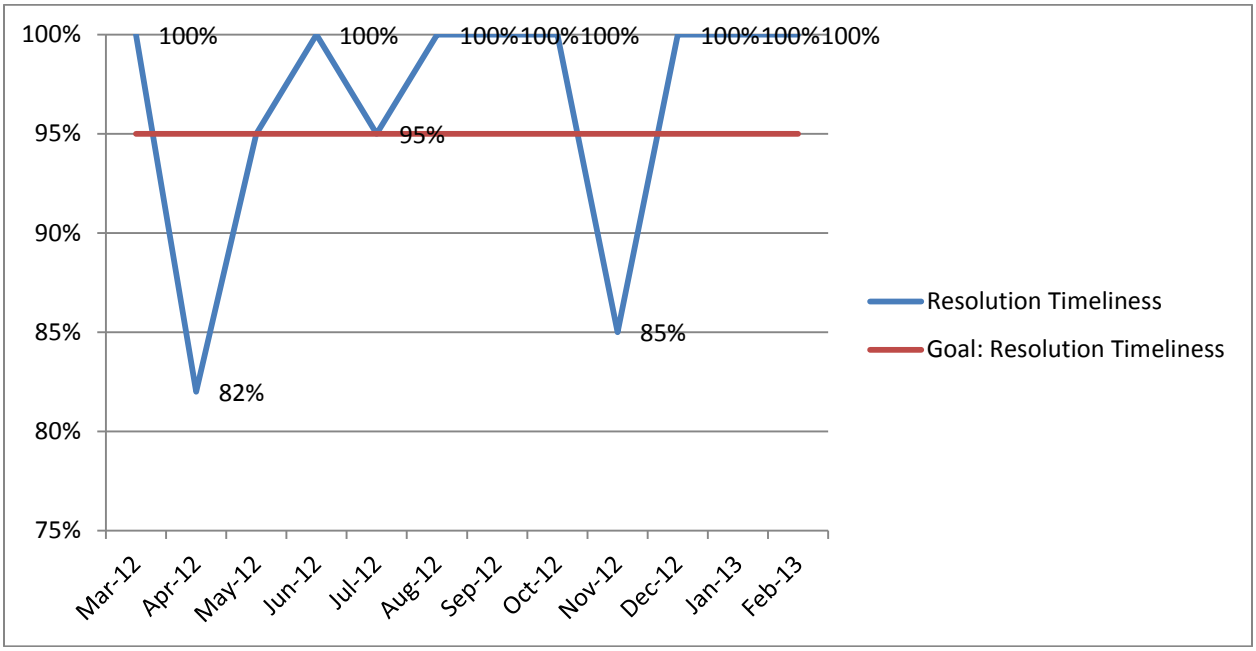
Of the member appeals, 148 (75%) of the initial determinations were upheld, 24 (12%) were partially reversed, and 26 (13.0%) were reversed. 94% of standard member appeals were resolved within the 30-day resolution timeframe, with 98.5% of expedited member appeals resolved within three (3) business days of the request. Of the provider disputes filed, 104 (84%) were upheld. Seven (6%) were partially reversed, with 13 (10%) were reversed.

While timeliness has improved over the months, the LA CMC is now focusing on improving the quality of services the Appeals Department provides. To that end, the department has contracted with an external auditor to perform quality audits of 100% of their reviews. Further, additional staff trainings have been taking place to ensure that staff has a clearer understanding of the procedures and internet applications going forward. Claims disputes are closely monitored to ensure that all timeframes are met for this process.

The following graph represents standard and expedited appeals figures from March 2012 to February 2013. The LA CMC has consistently noticed an increase in member appeals from March 1, 2012.

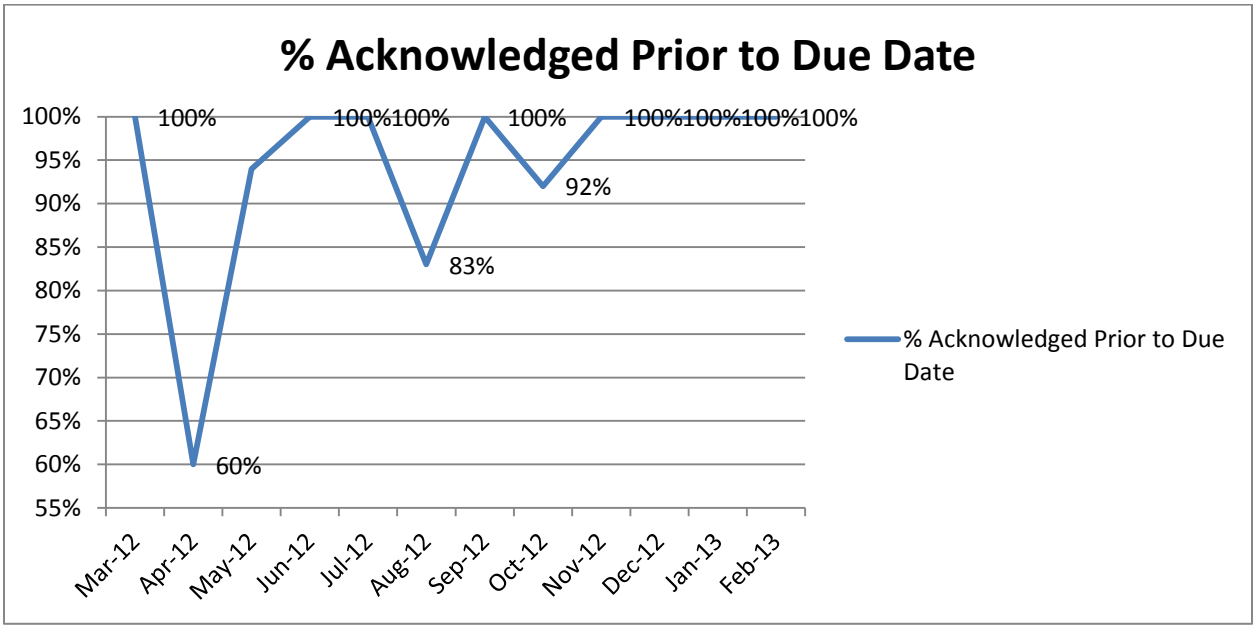



The graph below represents the timeliness of resolution of member appeals. While there is a good deal of variability in the timeliness of resolution, it should be noted that in 10 of the 12 months shown, the resolution timeliness goal was met. On only two occasions did the LA CMC fail to meet the timeliness goal of 95%. While there has been consistent performance with meeting the goal, the CMC will continue to look for and remove any barriers that may tend to preclude meeting the timeliness goal.




The last table illustrates that for eight of the months depicted, acknowledgement of an appeal occurred before the due date. Early on there was a significant drop in acknowledgment. Much

improvement has been made in the area of timely acknowledgment of appeals. However, measures have been taken to ensure a higher, more consistent rate of acknowledgment.




As the graphs above show improvement, it is understood that further opportunities exist to realize continuous, consistent growth. To that end, interventions have been put in place to effect improvement.

## XVIII. Provider Site Visits

The network department of the Magellan of Louisiana CMC is responsible for assessing the quality, safety, and accessibility of office sites where care is delivered. The LA CMC conducts site visits with providers as part of routine monitoring and credentialing activities. During 2012, 150 providers were visited onsite for review as part of the credentialing process. All providers were found to be compliant with all review elements. However, one (1) provider was placed on an action plan due to policy and procedure issues.

Magellan providers are expected to meet NCQA standards dealing with physical accessibility, physical appearance, adequacy of the waiting and examining room space, and adequacy of treatment record keeping. If the CMC receives any complaints about a facility not meeting standards, then the network department performs a site visit. Further, any provider who receives 3 or more complaints during a six-month period may be scheduled for a site visit as part of RNCC oversight activity. During this past year, there were no site visits that met the threshold of a complaint based on NCQA standards.

In addition, site visits are conducted to monitor treatment record documentation. Any provider scoring 70% or below on the treatment record review is required to submit a formal corrective action plan with a follow-up visit in 6 months to assess for improvement. If concerns are noted

through site visits for standards compliance or treatment record reviews, the results are reviewed in the Regional Network Credentialing Committee (RNCC) for discussion and recommendations on corrective action plans and credentialing decisions.

Finally, targeted educational efforts were conducted by Network staff via onsite visits, phone, and mail during the contract year. Education with providers was targeted to reinforce authorization and claims submission requirements and processes.

## XIX. Recovery and Resiliency Care Management Program Effectiveness

The Recovery and Resiliency Care Management (RCM) policy was approved on 06/28/2012. As part of development, the Program enrollment criteria were modified to mirror the language in the Louisiana Behavioral Health Partnership (LBHP) contract. The population of focus for RCM includes members who meet the following criteria:

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

The RCM Program currently consists of 8 FTE Care Managers and 2 FTE Peer Support Specialists. Since initiation of the program through 2/28/13, 553 members have been admitted to RCM. Of the members admitted, 105 have been discharged, leaving 448 actively enrolled at end of year.

RCM Care Managers (CM) participated in “Train the Trainer” and “Plans of Care” trainings provided by their immediate supervisors. Two (2) RCM CMs are assigned to work with the five Bayou Health plans. The RCM unit has established a Birth Outcome Initiative that connects substance abusing expectant mothers to appropriate services. CMs complete crisis safety plans with members and attach the plan to each member’s file through the Magellan system. In

addition, RCM is providing education to Emergency Departments and providers about the existence and role of the RCM program.

Peer Support Specialists were moved from the RCM/Clinical Operations team to the Recovery and Resiliency team in August 2012. Since that transition, a referral process from the Care Managers to the Peer Support Specialists has been established for members who may need additional supports to remain in the community. Both Specialists became certified BRIDGES Educators during 2012. Peer Support Specialists have had contact with over 90 members and over 35 providers. Peer Support Specialists have been integral in collecting CHI Surveys and educating CMC staff regarding their roles.

RCM is currently managing 560 cases with 5.5 full time Care Managers averaging 102 cases per care manager. At present, face to face member visits by Peer Support Specialists are limited to regions 2 and 4. RCM would like to add Peer Support Specialists for increased face to face visits which help to build engagement. A satisfaction survey is being planned for future use with RCM members. In addition, outcomes of the Consumer Health Inventory (CHI) will continue to be collected by Peer Support Specialists and CMs.

The RCM program experienced barriers in 2012 consistent with a start up, the nature of the population served, and staffing needs. The first related to the implementation process. During the initial months of start up, the LA CMC experienced high volume triage phone queues that required utilization of all Care Managers to manage. The RCM program was formally staffed and implemented in September 2012, after the triage call volume decreased.

Another barrier faced by the RCM program is that many members do not have access to phones. To address this barrier, the Office of Behavioral Health and Magellan of Louisiana have contracted to provide cell phones to 1915i waiver members to increase communication with that population.

Completion and entry of CHI information remains an opportunity for improvement and RCM staff is working to ensure the CHI is accurately captured and data entered in an efficient way. In order to expand the RCM program activities, additional staff, especially Peer Support Specialists, is needed to be able to cover additional regions throughout the State.

RCM Care Management/Clinical Goals for the 2013 contract year include:

- Reach enrollment capacity of a minimum of 60 members per FTE RCM Care Manager
- Complete CHI with 80% of RCM participants
- Ensure compliance with established workflows
- Develop proposal and justification for adding more Peer Support Specialists to the program.
- Have RCM CMs begin the RCM Care Manager Certification process.

Recovery and Resiliency Peer Support Specialists Goals for 2013 Include:

- Recovery and Resiliency presentation at the January 2013 Clinical Operations meeting.
- Continue growth in member caseload to attain a maximum capacity of 30 by the end of the 3rd Quarter.
- Identify services that can be provided within limited travel budget.
- Develop community-based events and services such as a Peer Centered Health and Wellness Fair, and Faith-Based Initiatives that link RCM members to additional community resources.
- Track the need for institutional services. As access to community resources increases, it is expected that formal institutional services will be needed less often.
- Establish RCM member support groups.
- Implement the Warmline Initiative by July 2013 on a limited basis. The Warmline is a peer staffed hotline to provide non-judgmental peer support.

## XX. Evaluation of Over and/or Under Utilization

I. Purpose

Magellan is committed to providing quality services to the members served. The accuracy of clinical information provided by members and network providers is relied upon in order to make service authorization determinations. Magellan wants to ensure that members are receiving individualized care that is effective, provided in the least restrictive setting, and medically necessary. Therefore, it is imperative that members receive the appropriate level of care while not over or under utilizing services. In order to identify trends in service utilization in Louisiana, the QI department conducts an annual analysis. This implementation year analysis serves as a tool in recognizing and addressing prospective areas of over or under utilization for mental health and chemical dependency services in Louisiana, which can be monitored going forward.

II. Measurement Period: March 1, 2012-February 28, 2013

III. Measurements Used

A. Admits/1000 Mental Health (MH)

To obtain a clear understanding of how members are utilizing inpatient services; Magellan evaluated the numbers of inpatient admissions for mental health services. Limitations on access, UM program issues resulting in delays in obtaining authorization, denials of service that are appropriate for the member's needs, and provider or practitioner issues could lead to under utilization of this level of care and would be reflected in this measure. Lack of availability of appropriate alternative services and provider and practitioner issues could result in over utilization and would be reflected by this measure. In addition, over or under utilization of this measure may have possible impacts on different variables such as the number of quality of care concerns, treatment outcomes, restrictions and limits on access to healthcare resources for our

members. Due to the recent implementation of managed care in Louisiana and the variability and adjustments to this change in network and care management processes, no goal range or benchmark has been established as a comparative marker, though data can be compared to that seen national Medicaid population (refer to Section V below).

- During the measurement period, 17,193 authorizations for inpatient care were entered for mental health admissions. This equates to 14.76 mental health admissions per 1,000 members of the Louisiana Medicaid population.

B. Admits/1000 Substance Abuse Residential (SA)

As with the number of admits/1000 for mental health, the Louisiana CMC wants to recognize any trends associated with members and examine use of inpatient admissions to substance abuse residential facilities. If members are over utilizing these services the probable impact, in terms of capital, could be higher cost compared to other levels of care that may be suitable for members' needs. The effects of under utilizing services may account for risks associated with the welfare of the members and treatment results as well. As discussed above, due to the recent implementation of managed care in Louisiana and the variability and adjustments to this change in network and services, no goal range or benchmark has been established as a comparative marker.

- There were 3,406 admissions during the measurement period. This translated into 2.92 admissions per thousand for the Louisiana Medicaid population.

C. Average Length of Stay (ALOS) – Mental Health

- Analyzing ALOS is an effective way of assessing how long members receive services for each particular level of care (see Table below). Length of stay is defined as the average number of days between admission and discharge of behavioral health recipients at inpatient mental health facilities. This measure is also widely used to measure and monitor utilization. An ALOS shorter than expected may reflect under utilization related to an inappropriate impact of the UM process, inappropriate denials, quality of care or other provider or practitioner issues, or other issues. An ALOS longer than expected may reflect delays or a lack of availability of access to alternative levels of care, issues with the UM process for alternative levels of care, quality of care or other practitioner or provider issues resulting in increased lengths of stay and over-utilization. Inpatient hospitalization is one of the most costly services, and although selected inpatient stays may not be preventable, it is important to identify resources that can be used to reduce inpatient stays and ensure the member is treated in the least restrictive setting.

- Based on claims data, the ALOS for mental health in the Louisiana Medicaid population was 8.4 days

D. Average Length of Stay (ALOS) – Substance Abuse

- Based on claims data, the ALOS for substance abuse inpatient admissions in the Louisiana Medicaid population was 6.6 days

| | Mental Health | Substance Abuse | **Total |
|---|---|---|---|
| **Unique Users** | 12,171 | 579 | 12,622 |
| **Admissions** | 17,193 | 636 | 17,829 |
| **Discharges** | 16,850 | 624 | 17,474 |
| ***Admissions/1000** | 14.76 | 0.55 | 15.31 |
| ***Discharges/1000** | 14.46 | 0.54 | 15.00 |
| **Average Length of Stay** | 8.4 | 6.6 | 8.3 |
| **Penetration Rate** | 1.04% | 0.05% | 1.08% |

* Average # of covered lives-1,164,898
** Users may be counted multiple times if they change levels of care and/or have MH and SA claims within the same specified incurred and paid period.

The QI department compared the aggregate inpatient data to national Medicaid population data compiled by the Kaiser Family Foundation in 2009. The national aggregate measures are listed below.

- Inpatient behavioral admits (30.1/1000)
- Inpatient behavioral ALOS (7.2 days)

As the data shows, there are significantly lower behavioral health inpatient admissions (combined MH/SA) for the Louisiana CMC (15.0/1000) than seen in the Kaiser report. There are numerous confounding factors which make comparison across Medicaid populations problematic. These include varying benefit/level of care structures, population types, and eligibility criteria from state to state.

The Louisiana CMC's average length of stay for inpatient behavioral health (MH/SA) at 8.3 days is slightly higher than that seen with the data from the Kaiser Family Foundation (7.2 days). As stated above, due to lack of detail surrounding the populations compiled, it is difficult to state why these differences are seen. At this time, the Louisiana CMC will continue to monitor inpatient data both admissions and ALOS and track for trends.

E. Readmissions

- An analysis of readmission rates may be used as a key indicator of over and under utilization. The readmission measure is used to monitor higher than expected

readmission rates and may reflect either under-utilization or over-utilization of inpatient care. High rates may result from pre-mature discharge from a prior admission due to issues related to providers, practitioners, or the UM process, delays or lack of access to follow-up care or alternative levels of care following discharge, or quality of care issues with providers and practitioners reflecting under-utilization. High rates may also reflect practitioner or provider issues contributing to inappropriate admissions, or the delay or lack of availability of alternative levels of care resulting in over utilization of the inpatient level of care.

- Further, when using a drilldown approach, readmissions can be used to identify high utilizers, providers that may have a tendency of discharging their patient before they are medically stable, lack of quality discharge plans, lack of support services, and need of other levels of care to be utilized. Identification of these trends helps provide insight to alternative levels of care that may be used as well as decreases the cost associated with members readmitting to inpatient care (see Table below).

- Magellan has established a threshold goal of $\leq$ 15% for overall readmissions. The annual result for March 1, 2012 through February 28, 2012 was 13.09%, which met the goal of 15% or less. Quarter results for the first contract year are presented in the table below.

| 2012 | 30-day Readmit | FU 7-day % | FU 30-day % |
|---|---|---|---|
| 1st Quarter | 12.25% | 26.60% | 46.50% |
| 2nd Quarter | 13.03% | 28.13% | 48.10% |
| 3rd Quarter | 12.86% | 27.53% | 50.03% |
| 4th Quarter | 13.93% | 30.30% | 47.80% |

F. Ambulatory Follow-up

- Ambulatory Follow-up is a measure use to measure compliance with follow-up after inpatient discharge for members with mental health diagnoses. The metrics used look at those members attending an aftercare appointment with a behavioral health provider within 7-days and 30-days post discharge. Monitoring these measures allows Magellan of Louisiana to identify opportunities for improvement when assessing the coordination of obtaining aftercare appointments.

- Magellan establishes its goal based on the HEDIS Medicaid national averages for Ambulatory Follow-up for 7-day and 30-day, which are 47 and 65 respectively. The annual results were 29.10% for 7-day follow-up and 48.40% for 30-day follow-up. Quarterly results for the year are presented in the table above.

## IV. Areas of Opportunities

Based on analysis of the results of the utilization measures previously outlined, it was concluded the following actions should be considered to improve utilization at the Louisiana CMC:

- Development of utilization reports which provide further breakouts of the major population categories within the Louisiana Medicaid system; addition of major population categories is needed within the Magellan Enterprise reporting system.

- Identification and develop interventions to improve readmission and follow-up rates.

- Enhanced monitoring with interventions directed at the segment of the inpatient population considered utilizers.

- Promote provider adherence to clinical practice guidelines through the Treatment Record Review process

- Continued monitoring through the Utilization Management Committee and Network assess effectiveness of efforts to reduce readmissions and increase follow-up rates.

## XXI. Consumer, Family and Stakeholder Input and Involvement

### Communication with Members

Magellan of Louisiana involves several ongoing groups of consumers, family members, providers and other stakeholders in its Quality Improvement and Utilization Management programs. Through this involvement, the Magellan of Louisiana CMC is able to gain valuable input and is thus able to distribute information related to furthering the principles of recovery, resiliency, stigma reduction and cultural competence to all stakeholders.

In 2012, Magellan of Louisiana established the Family, Member and Stakeholder Advisory Committee (FMSAC) to develop the foundation, mission, vision and goals for activities which are set to commence in 2013. The Family, Member and Stakeholder Advisory Committee met five times during the contract year with ten to fifteen individuals attending each meeting. These individuals were from the community and were not in any other way associated with Magellan. The Family, Member, Stakeholder Advisory Committee performed the following activities:

- Developed a membership roster consisting of representatives from family, advocate, member and private sector groups
- Reviewed each category identified in the Quality Improvement workplan
- Created and uploaded related documents to the FMASC Agenda & Minutes folder in the “G” drive Quality Improvement folder according to URAC Accreditation Standards
- Reviewed and prioritized goals for the upcoming calendar year

Building from the base established during 2012, the following activities are proposed for 2013:

- Hold monthly meetings
- Reach out to and incorporate underrepresented groups
- Integrate speakers in each meeting for educational purposes regarding Magellan of Louisiana processes
- Develop action plans for groups with specific targets
- Obtain input on member initiatives, satisfaction survey findings, and opportunities for improvement of services to the Medicaid population

In 2012, Magellan of Louisiana's Peer Support Specialists provided one-on-one and group support to Recovery Care Management (RCM) members who were identified as being the most at-risk. Peer Support Specialists also worked with members to develop individual-centered plans to decrease dependency on institutional care and to shift the focus instead on community-based services. The Peer Support Specialists performed the following activities in 2012:

- Identified Recovery Care Management members who could benefit from one-on-one services
- Connected with at least 90 RCM members
- Participated in community-based events
- Aided in increasing awareness of services available to members
- Conducted CHI surveys with members telephonically and in-person

Also during 2012, Magellan of Louisiana's Member Services Committee distributed 350,000 fat bookmarks, as an educational piece informing members of Magellan's presence in Louisiana and how to contact us.

**Communications with Providers**

As part of implementation processes, Magellan of Louisiana established the Network Strategy Committee to serve as a conduit for information regarding evidence-based practices and a hub for information gathering/sharing and strategic planning for what is happening with the provider network within each region. The Network Strategy Committee was also established to serve as a source of feedback to the provider network. Due to absence of administrative leadership, the committee only met once in 2012. Regular meetings commenced in February 2013.

However, provider input and feedback was captured through other venues including all-provider conference calls which are held every Thursday to address the changing needs of Magellan providers within the Louisiana Behavioral Health Partnership, feedback during site visit reviews by Network and QI Staff, as well as weekly conference calls which include provider support from the Bayou Health Plan. The focus of these calls will continue to be general questions regarding billing/claims procedures and the Clinical Advisor system as will as any other feedback providers offer.

Information is given to providers through the Magellan Behavioral Health Partnership Provider News newsletter each month, which is a summary of the latest news for network providers, state legislators and community stakeholders.

**Communication with Other Stakeholders**
In 2012, Magellan of Louisiana established a Governance Board to offer community stakeholders a voice and share decision-making authority in shaping the vision, strategy, planning, decision-making and oversight of the statewide program. The board supervised and reviewed the following areas:

- Overall program vision and direction
- Clinical policy
- Overall recovery/wellness policy
- Provider reimbursement guidelines
- Network composition
- Review of quality improvement (QI), complaint and grievance reports, and best practices
- Review of best practices and action plans
- Training policy
- Operating policy
- Strategic planning
- Establishment and monitoring of ad-hoc advisory committees and workgroups
- Oversight of action plans and performance improvement projects
- Performance Guarantees
- Adverse Incidents and Quality of Care Issues

**Availability of Consumer Related Printed Matter and Processes**
As discussed earlier in this evaluation, the entire LA CMC website and the member handbook are available in Spanish and Vietnamese, as are the Notice of Action letters sent to members. Magellan also makes the following material available at an easily understood level and in the languages of the commonly encountered populations. This includes correspondence related to:

- Complaints and compliments
- Educational materials
- Grievances
- Quality of care concerns
- Appeals
- Satisfaction surveys

**Community Involvement**
Magellan staff is committed to cultural diversity through partnerships within the community. Magellan works to identify and involve community resources for purposes of integrated member support and service delivery. This involvement is important to assure that all consumers have coordinated care with community-based entities and services. Some of these

services include, but are not limited to family members, community councils, churches and spiritual leaders, civic clubs, community organizations, schools, social services, public health and other healthcare related associations and organizations.

Community support and resources are particularly important as an adjunct in the treatment of behavioral health and substance abuse disorders. Magellan maintains a current listing of community resources in the service areas of the member population. Magellan RCM team, in particular, uses community resources to coordinate care and assist in community transition issues.

## XXII. Accreditation and External Review

In early 2012, Magellan corporate initiated an internal review of all behavioral health Care Management Centers. This review, known as the System and Clinical Organizational Review (SCOR) Program, was conducted as a 3-day onsite at the Louisiana CMC in November 2012. The following activities/processes were assessed during the visit.

- Access & Availability
- Action Plan Development & Progress
- AI/QOC/Patient Safety
- Ambulatory Follow-up
- Appeals
- Authorization Decision Timeliness
- Claims Disputes
- Clinical Files
- Coordination of Care
- Denials
- Fraud, Waste, and Abuse
- HEDIS Oversight & Structure
- HIPAA/Security/Disaster Planning
- Letter Development & Protection
- Medicaid /Regulatory Compliance
- Medical Action Plan
- Member Complaints & Grievances
- Outcomes Program
- PA Documentation & Monitoring
- Provider Complaints
- RNCC Operations
- Satisfaction Surveys
- Service Operations Functions
- Transition of Care/Provider Terminations
- Treatment Record Reviews

The findings from this survey have been used to help enhance the LA CMC's internal processes and workflows and better position the CMC in preparing for URAC accreditation. Progress related to opportunities for improvement is monitored by the CMC QI department and the national SCOR staff.

It was determined at the corporate level that Magellan Behavioral Health of Louisiana would go seek URAC Health Utilization Management accreditation in Fall 2013, rather than participate in the Magellan multi-site accreditation process during 2nd/ 3rd quarter 2013. In preparation for the URAC application submission and site survey, a pre-assessment survey was conducted during first quarter 2013 by Magellan corporate staff including the Senior Vice President of QI, Research and Outcomes, the Vice President of QI, and the National Director of QI. The following areas were reviewed: organizational structure, policies and procedures, regulatory compliance, inter-departmental coordination, oversight of delegated functions, marketing and sales communications, business relationships, information management, quality management, staff qualifications, staff management, clinical staff credentialing and oversight, health care system coordination, and consumer protection and empowerment. The application for accreditation was submitted to URAC in January 2013.

URAC preparation at both the Corporate and CMC level is a continuous process. The National Director of Quality and Accreditation coordinates the development and implementation of review tools and assessments and an annual MAUC audit is conducted to monitor for ongoing preparedness. Preparation includes a review of new URAC standards against existing Magellan policies, development of web-based review tools, training for divisional staff to conduct the reviews, and orientation of CMCs to any new initiatives.

## XXIII. Resources

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

- Quality, Outcomes and Research Department which supports the LA CMC by providing direction on the identification, implementation, and documentation of Quality Improvement Activities and Performance Improvement Projects, QI document templates
- Corporate Survey Office implements satisfaction surveys for members, providers, and customer organizations.
- Analytical Services Department which provides the LA CMC with data reports on several QI and UM indicators and provides consultation on report definitions and analysis.
- Network Services Department which supports the LA CMC by verifying the accuracy of credentials submitted by providers for inclusion in the network.
- National Clinical Management Department which supports the LA CMC through the development 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 at the Corporate Committees level and through those that occur in the LA CMC.

- Corporate Compliance Department through the development of policy and standards, monitoring of HIPAA and related privacy and security practices and through operation of the Magellan Fraud and Abuse department.
- The Magellan LA CMC quality structure is comprised of specialty care and care management center committees. CMC senior management, members, healthcare practitioners, and representatives from medical delivery systems participate in the QI and UM programs through participation in the local committee structure, which includes the Quality Improvement Committee, Regional Network Credentialing Review Committee, Utilization Management Committee, and related bodies such as consumer, family member and stakeholder committees.
- The LA CMC QI program is supported locally through design, implementation, analysis, and reporting of QI data by the local and corporate IT office. Analytic capabilities include creation of database warehouses and sequel programming to access IP, CA, and claims data.

## XXIV. Delegation

The LA CMC 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 Magellan Louisiana Care Management Center (LA CMC) is committed to establishing a culture within the Care Management Center (CMC) that promotes adherence to applicable legal, contractual and policy requirements, and promotes the prevention, detection and resolution of conduct that does not conform to those requirements. In its effort to conduct business in a lawful and ethical manner, Magellan of Louisiana has designated one individual as a resource for reviewing and distributing State specific Medicaid regulatory updates and requirements to appropriate departments and staff. The Corporate Compliance Administrator maintains current understanding of Medicaid regulatory requirements and updates through the following:

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

The Corporate 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. Senior Management team meetings are held weekly. The Corporate Compliance

Administrator and senior management know where to locate and have immediate access to the current state Medicaid contract for reference as needed. A binder containing the RFP and other pertinent information was disseminated to the entire executive team. The Corporate Compliance Administrator is actively involved with the Quality Improvement Committee and is the facilitator for the Compliance Committee.

The Corporate Compliance Administrator ensures policies are customized per contractual requirements. Staff is responsible for member contract specific policies while compliance retains responsibility for regulatory requirements.

The Corporate 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 Corporate Compliance Administrator reviews, is familiar with and implements policies. The Corporate 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 Corporate Compliance Administrator. In addition, each staff member is required to complete an attestation insuring understanding of those procedures and guidelines. Annual trainings on State Medicaid requirements and changes affecting the Magellan of Louisiana CMC are underway. Links to applicable State Medicaid internet sites are also assessable through MagNet.

Within thirty (30) days of the implementation date of changes to the Corporate Compliance Program, current employees, physician advisors and behavioral health care professional advisors are advised of the changes through distribution of the revised Compliance Handbook or via the corporate intranet. The Corporate Compliance Administrator is also responsible for insuring process changes needed due to State requirements are implemented timely. Compliance with these changes is monitored post implementation.

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

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

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

External Sources:

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

Internal Sources:

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

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

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

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 Corporate Compliance Administrator also serves as the privacy officer and is responsible for the creation, implementation and maintenance of Magellan of Louisiana's privacy-compliance related activities. The HIPAA Desk Audits serve as another compliance monitoring method that is routinely employed by the Magellan compliance department to confirm Protected Heath Information (PHI) is controlled according to the HIPAA Privacy and Security requirements and Magellan's confidentiality policies and procedures, as well as to identify and assess areas of

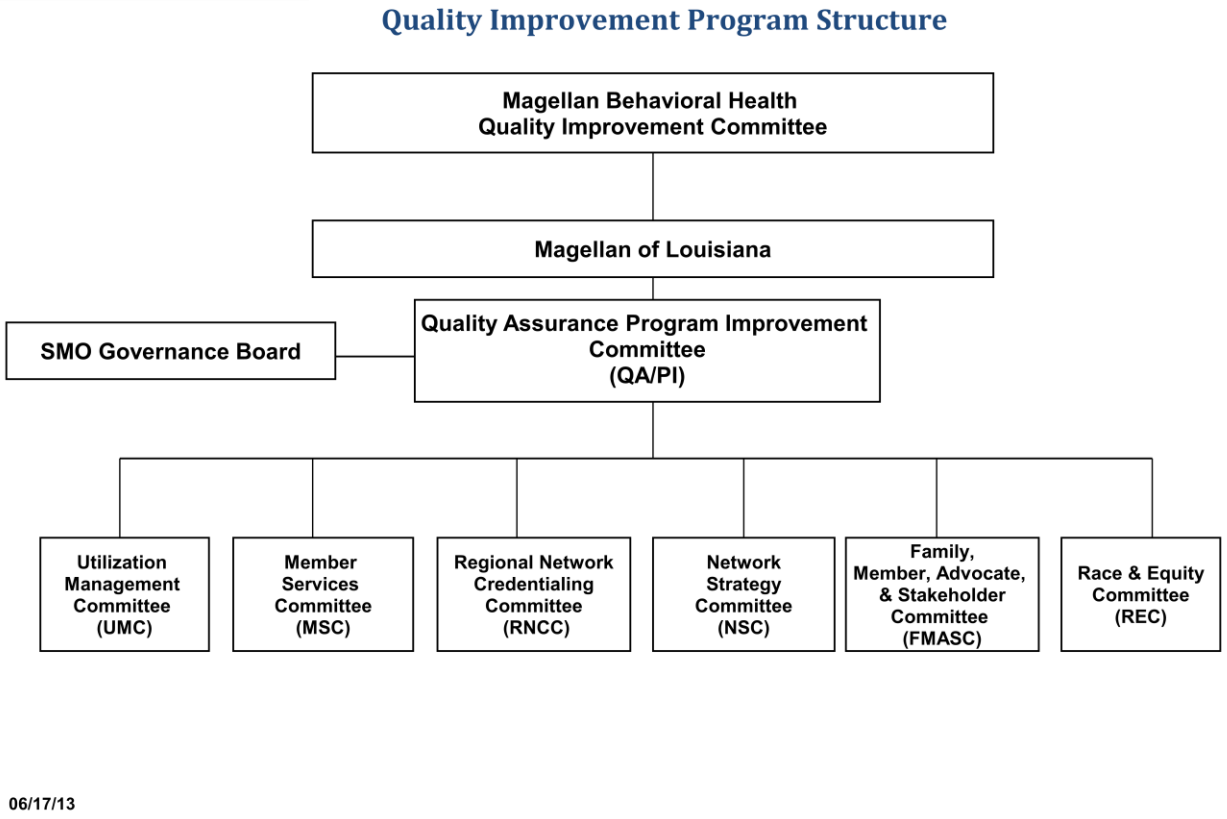
potential internal risk. In addition, Training Non-Compliance reports of annually mandated HIPAA/Privacy and Compliance trainings are routinely monitored and tracked by the Corporate Compliance Administrator, as these trainings are designed to help foster Magellan of Louisiana employees' awareness and 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 LA CMC achievements and opportunities for improvement, as well as prioritized areas for focus in 2013 are outlined in the Executive Report in the beginning of this annual report. The contents of this report and documentation provided in the Appendices summarize the LA CMC's on-going QI activities, the trending of measures to assess performance, an analysis of improvements and an overall evaluation of the effectiveness of the QI and UM programs. The LA CMC remains committed to on-going evaluation and improvement of care and services for members.

Since this the first year of operation for the LA CMC, there are no prior year comparisons. The notable achievements in the first year of operation were the development of the infra-structure (UM Department, Network Department, Care Manage, Quality Improvement, Member Services) that oversees the provision of services from a provider network composed of over 625 facilities, 215 groups, and 2,049 certified providers across the state. Over 115,000 services were authorized for members in the first year, which included Community Support Services, Psychiatric Rehabilitation Services, and Psychiatric Inpatient services. Prioritized goals for the coming year include the development of a strategy for addressing the needs of high utilizers, increasing mental health follow-up rates, achieving URAC accreditation, development of routine reporting for waiver requirements and developing electronic scoring of CANS assessments for improved reporting and tracking of clinical outcomes among CSoC children.

## Appendix A: Louisiana Care Management Center Quality Committee Structure



**Appendix B: Louisiana Care Management Center Resources Allocated to Quality Program**

The following table outlines the staff resources going into 2013 based on FTEs allocated to meet the needs of the QI program.

| LA CMC Staff | Percent of FTE Allocated to QI |
|---|---|
| Chief Executive Officer | 15% |
| Chief Operating Officer | 35% |
| Chief Medical Officer | 60% |
| Medical Administrator | 40% |
| Physician Advisor (7) | 25% |
| UM/CM Administrator | 40% |
| Manager, Clinical Services (4) | 20% |
| Director Customer Service | 40% |
| Corporate Compliance Officer | 50% |
| Quality Administrator | 100% |
| QI Manager | 100% |
| QI Clinical Reviewer (8) | 100% |
| QI Reporting Manager | 75% |
| QI Data & Reporting Analyst | 75% |
| Grievance & Appeals Administrator | 100% |
| Trainer (Clinical & Service) (2) | 100% |
| Follow-Up Supervisor | 100% |
| Director Network | 30% |
| Manager Area Contracting | 30% |
| Network Coordinator (2) | 20% |
| LAN Administrator | 20% |

| Corporate Staff | Percent of FTE Allocated to QI |
|---|---|
| Senior Vice President, Outcomes & Research | 15% |
| Vice President Quality Improvement | 30% |
| National Director, Quality Improvement | 30% |
| National Director, Quality & Accreditation | 20% |
| Vice President, Outcomes & Evaluations | 10% |
| Vice President, QI Performance Measurement | 10% |
| Chief Medical Officer – Behavioral Health | 20% |

| Technical Resources |
|---|
| Clinical Information System |
| IP |

| Technical Resources |
|---|
| Claims System |
| CAPS |
| Eligibility/Authorization System |
| IP |
| Other Technical Resources |
| Microsoft® Office Suite |
| Provider Stand Alone Search |
| Visio® Basic |
| Microsoft® Project |
| MagNet |

| 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, Complaints, Appeals, Grievances |
| HEDIS® |
| Member Satisfaction Survey System |
| Monthly IUR Summary Report |
| Practitioner Satisfaction Survey System |
| Practitioner Profiling Report |
| Intensive Care Manager Reports |
| Readmission Report |

## Appendix C. Care Management Center LA CMC 2012 Workplan Performance Measures

| Performance Measure | Goal | Outcome | Action |
|---|---|---|---|
| Average Speed of Answer (ASA) (member Services) | ≤ 30 seconds | Met established goal | Continue to monitor |
| Call Abandonment Rate | ≤ 5% (Year 1) | Met established goal | Continue to monitor |
| Emergent Care (w/i 1 hour of request) | ≥ 95% | Multiple measures triangulated to look at appointment access.<br><br>Determination timeliness – met goal<br><br>Time from request to claim for service – 93.5%; slightly below goal | Finding is slightly below goal of 95%. Appointment access offers opportunity for improvement. The Performance Improvement Project for this topic will be continued into Year 2. Monitoring of provider appointment availability will be added as an additional measure. |
| Urgent Care (Within 48 Hour of Referral) | ≥ 95% | Multiple measures triangulated to look at appointment access. Determination timeliness – met goal<br><br>Time from request to claim for service – 71.2% - did not meet goal | Result is below goal of 95% by 23.8 percentage points. Appointment access offers opportunity for improvement. The Performance Improvement Project for this topic will be continued into Year 2. Monitoring of provider appointment availability will be added as an additional measure. |
| Routine Care (Within 14 Calendar Days) | ≥ 70% | Multiple measures triangulated to look at appointment access. Determination timeliness – met goal<br><br>Time from request to claim for service – 74.7% - met goal | Though results met established goal, appointment access offers opportunity for improvement. The Performance Improvement Project for this topic will be continued into Year 2. Monitoring of provider appointment availability will be added as an additional measure. |
| 30-Day MH Readmission | ≤ 15% (Year 1) | 15.67% | Annual result exceeded established goal; interventions have been implemented to address (Note: recent trends post 2-28-13 indicate a decrease) |

| Performance Measure | Goal | Outcome | Action |
|---|---|---|---|
| Emergency Department | Monitoring Indicator | ER Visits (unique members) – 12,701<br><br>All ER Visits – 18,195 | Activities in place to track high utilizing members to offer/provide supports to promote care at an earlier point and lower level |
| Inpatient MH: 7 - Day Follow-up Rate | ≥ 45% | 28.1% | Performance improvement plan developed; implementation is in process |
| Inpatient MH: 30 - Day Follow-up Rate | Monitoring Indicator for 2012 | 55.0% | Performance improvement plan developed; implementation is in process |
| Number Served in WAA, MST, and FSO programs implemented with fidelity | Monitoring Indicator | 2,723 unique individuals served in WAA, MST, and FSO programs | Magellan is initiating the fidelity assessments of evidence based programs |
| Number of Children Served with Wraparound plans | Monitoring Indicator | Total enrollment in WAAs during the year was 1,295; at year end, 723 CSoC children were enrolled with the WAAs; each child had a plan of care developed | Survey CSoC families to determine barriers which may prevent access to services in order to facilitate development of targeted interventions. |
| Community Resources Utilized (CPST, PSR, Independent Living, Respite, Parent & Youth training, and Case Conference) | Monitoring Indicator | 2,172 service authorizations (non-unique children) for community resources<br><br>96% of CSoC children authorized for CSoC Waiver services, however only 43% had claims for these services. | Identify barriers that prevent CSoC children from receiving authorized services<br><br>Develop interventions to improve the rate at which CSoC children receive additional CSoC services. |
| Decreased number of CSoC youth placed in restrictive settings, including psychiatric inpatient settings | Monitoring Indicator | 26.8% of CSoC children had restrictive placements prior to enrollment in WAA<br><br>13.3% of CSoC youth had restrictive placement after enrolling in WAA | The CSoC program, in comparison to a matched group, appears to have helped reduce placement in restrictive settings.<br><br>Continue interventions to improve use of CSoC services and monitor for trends as the provider network expands and children receive more authorized services. |
| Decreased School | Monitoring | Suspensions | Trends are in a positive |

| Performance Measure | Goal | Outcome | Action |
|---|---|---|---|
| Suspensions/Expulsions | Indicator | • R1 – 27.0<br>• R2 – 24.0<br>• R3 – 15.0<br>• R4 – 6.0<br><br>Expulsions:<br>• R1 – 5.0<br>• R2 – 7.0<br>• R3 – 7.0<br>• R4 – 3.0 | direction and should continue as wraparound services become more comprehensive. |
| School Attendance Rates | Monitoring Indicator | • R1 – 3.53<br>• R2 – 2.55<br>• R3 – 2.20<br>• R4 – 1.42<br><br>*Due to inability to obtain attendance data, calculation is mean days missed (excluding suspensions/ expulsions) | Trends are in a positive direction and should continue as wraparound services become more comprehensive. |
| Use of Peer Support Services | Monitoring Indicator | 1,653 authorizations for Peer Support Services<br>150 claims filed for Peer Support Services | Identify barriers that prevent CSoC children from receiving authorized services<br><br>Develop interventions to improve the rate at which CSoC children receive peer support services. |
| Number of Crisis Plans Developed/Implemented | Monitoring Indicator | 4 (0.3%) crisis plans were implemented during the contract year | The CSoC program appears to have helped stabilize families since only 4 crisis plans were implemented in the contract year.<br><br>Continue to monitor for trend |
| Adult High Service Users (% w/ $\geq$ 2 IP Admissions or 4 ER visits per year enrolled in ACT or Psych Rehab | Monitoring Indicator | 12% | Opportunity for improvement in identification and follow-up; interventions to address under development |
| ALOS in Inpatient Facilities | Monitoring Indicator | 8.4 | ALOS was slightly above the national aggregated Medicaid ALOS (based on Kaiser Foundation data). It is |

| Performance Measure | Goal | Outcome | Action |
|---|---|---|---|
| | | | noteworthy that there has been a slight downward trend in ALOS for both children and adults across the contract year. Interventions are in place to ensure care is received as appropriate in the least restrictive setting.<br><br>Continue to monitor for trend. |
| Suicides/Homicides/Abuse/Neglect | Monitoring Indicator | 1 successful suicide; 2 suicide attempts were reported<br><br>0 reports of Abuse/ Neglect | Each individual incident was investigated, reviewed and followed-up, as needed, by the overseeing RNCC with corrective actions and appropriate oversight as determined.<br><br>No recommendations for changes to the review process for 2013 and adverse incidents will continue to be investigated, reviewed, and followed, using the established guidelines. |
| Critical Incidents Investigated | Monitoring Indicator | Adverse incidents – 45<br><br>QOC concerns - 165 | Each is reviewed by the Clinical Reviewer in collaboration with the CMO, when warranted. AIs and QOCs are carefully reviewed and discussed in the AI subcommittee. Those requiring peer review and recommendations are presented to the RNCC. |
| Incidents Involving use of Restraints | Monitoring Indicator | 17 incidents of use of seclusion and restraints during the first contract year | Monitor for trend and opportunities for improvement |
| Medication Errors | Monitoring Indicator | 0 report of medication error through the AI/QOC process | Continue to monitor |
| Security Incidents/HIPAA Violations | Monitoring Indicator | Security Incidents - 0<br><br>HIPAA Violations - 101 | Each incident reported is investigation for root cause by the Chief Compliance Officer; interventions to prevent future occurrences are taken based on findings. |

| Performance Measure | Goal | Outcome | Action |
|---|---|---|---|
| | | | Additionally monthly monitoring is conducted in the LA CMC office to ensure staff are compliant with privacy requirements |
| Member Complaints/Grievances Received | Monitoring Indicator | 39 grievances received during the contract year | Education efforts were implemented in 2012 to ensure accurate reporting of all complaints/grievances.<br><br>Ongoing reminders/refresher trainings are planned for 2013 |
| Complaints/Grievances per 1000 Members | Monitoring Indicator | 0.0003*<br><br>*Calculated based on number of members seeking services | Continue to monitor for trend |
| Resolution Responsiveness | ≥ 90% | 93.5% of complaints/ grievances were resolved within required timeframes | Though goal was met, the CMC strives to respond promptly to every complaint/grievance received.<br><br>Continue to monitor for trend |
| Complaint/Grievance Categories | Monitoring Indicator | The categories with the highest numbers were:<br>1) Quality of Service;<br>2) Quality of Care;<br>3) Billing | Continue to monitor for trend |
| Provider Overall Satisfaction with Magellan 2ND year goal | ≥ 75% (Year 1) | Overall satisfaction – 80.2% - met established goal | Action plans under development to address individual element opportunities for improvement |
| Overall Satisfaction w/WAA & Other Providers | Monitoring Indicator | Minors – 85.4%<br><br>Adult – 79.7% | Quarterly satisfaction survey under development to focus on waiver requirements<br><br>Action plans under development to address individual element opportunities for improvement |
| IP Pre-Cert Determination Timeliness | Monitoring indicator | TBD | |
| IP Overturn Rate | ≤ 20% | 25% | Result is 5 percentage points above established goal. This is |

| Performance Measure | Goal | Outcome | Action |
|---|---|---|---|
| | | | not unusual as the CMC must make organizational determinations within required time frames. Frequently attending providers are unable to provide additional information in needed time, therefore additional clinical is provided after the fact and is found to warrant an overturn.<br><br>Continue to monitor for trend. |
| 1st Level Expedited Clinical | ≥ 95% | 98.5% - met goal | Continue to monitor for trend |
| Appeals Resolution Timeliness | ≥ 95% | 93.8% | Appeals department is conducting process analyses to improve performance |
| Non-authorization rate | Monitoring Indicator | 1.4% | Continue to monitor |
| Financial Payment Accuracy (see Data Quality Policy for Metrics Involved in Determining Accuracy) | ≥97% | 99% - met goal | Continue to monitor |
| Procedural Accuracy* | ≥98% | 99% - met goal | Continue to monitor |
| Turn Around w/in 30-days | ≥95% | 98% - met goal | Continue to monitor |
| Turn Around w/in 45 days | ≥99% | 99% - met goal | Continue to monitor |

**Appendix D. Staff Trainings**

**Magellan in Louisiana**
**LA CMC Workplace Training Record**
**February 1, 2012 to March 30, 2013**

| Date | Title | Facilitator |
|---|---|---|
| 2/1/12 | Magellan Orientation | Finklang, Jill; Fiksman, Emily |
| 2/2/12 | Magellan Orientation | Finklang, Jill; Fiksman, Emily |
| 2/2/12 | Magellan Orientation | Finklang, Jill; Fiksman, Emily |
| 2/21/12 | CANS | Foster, Dawn |
| 2/27/12 | Magellan Security | Jules, Sheila |
| 2/28/12 | Magellan Security | Jules, Sheila |
| 3/16/12 | Magellan/APA Standards for the Treatment of ADHD | Kunen, Seth |
| 3/21/12 | URAC Preparation | Winderbaum, Steve |
| 3/23/12 | MDD | Cooper, Tammy |
| 3/30/12 | Substance Abuse Education | Brown, Eric |
| 3/30/12 | FAH Workflows | Gonzales, Ricardo |
| 4/2/12 | TRR Tool | Kunen, Seth |
| 4/4/12 | Cultural Awareness 101 | Blue, Robert |
| 4/6/12 | Magellan Security | Gatson, Eboni |
| 4/6/12 | Ethics | Kunen, Seth |
| 4/9/12 | FAH Workflows | Gonzales, Ricardo |
| 4/11/12 | QI TRR Review | Dale, Sandra |
| 4/13/12 | Orientation Info Manager | Shavers, Ra'Quel |
| 4/13/12 | Ethics, Part II | Kunen, Seth |
| 4/20/12 | SCOR & RFP | Kunen, Seth |
| 4/27/12 | Outcomes, Reports, Projects | Dunn, Barbara |
| 5/4/12 | ASAM/LOCUS | Schum, Galen; Jones, Mary |
| 5/4/12 | FAH Workflows | Gonzales, Ricardo |
| 5/10/12 | FAH Workflows | Gonzales, Ricardo |
| 5/16/12 | Workplace Bullying | Blue, Robert |
| 5/18/12 | HIPAA | Kunen, Seth |
| 5/22/12 | TRR | Brown, Eric |
| 5/25/12 | Mental Illness Surveillance Stats | Kunen, Seth |
| 5/31/12 | WAA Tools | Cicely Evans |
| 5/31/12 | Ambulatory Follow-up | Shavers, Ra'Quel |
| 6/1/12 | TRR-CPG | Brown, Eric |
| 6/5/12 | Ambulatory Follow-up | Shavers, Ra'Quel |
| 6/7/12 | Adverse Incidents/Quality of Care Concerns | Burns, Shantell |

| Date | Title | Facilitator |
|---|---|---|
| 6/08/12 | Developing PP Presentations and IQ Info | Kunen, Seth |
| 6/14/12 | Meet Up Application | Gatson, Eboni |
| 6/15/12 | URAC Overview | Taylor, Charlene |
| 6/21/12 | Integrated Product | Jones, Mary |
| 6/21/12 | URAC—Follow-up V.P. Visit | Brown, Eric |
| 6/22/12 | Treatment Record Review | Brown, Eric |
| 6/29/12 | FAH Workflows | Gonzales, Ricardo |
| 7/2/12 | Ambulatory Follow-up | Shavers, Ra'Quel |
| 7/6/12 | Quality of Care | Kunen, Seth |
| 7/13/12 | TOMS | Kunen, Seth |
| 7/20/12 | Statistics/Chart Audits | Kunen, Seth |
| 7/27/12 | Guidelines for the Practice of Telepsychology | Kunen, Seth |
| 7/30/12 | Notice of Action (NOA) Denial Letters | Jones, Mary |
| 7/31/12 | Notice of Action (NOA) Denial Letters | Jones, Mary |
| 8/02/12 | URAC Kickoff | Albright, Joann |
| 8/03/12 | Medical Necessity Criteria | Kunen, Seth |
| 8/3/12 | Follow-up After Hospitalization Workflows | Gonzales, Ricardo |
| 8/9/12 | CSOC Referral Form | Moore, Levillia |
| 8/9/12 | Notice of Action (NOA) Denial Letters | Jones, Mary |
| 8/10/12 | Substance Abuse | Brown, Eric |
| 8/21/12 | Web-Based Case Logix | Dixon, Lynelle |
| 8/17/12 | Antipsychotics, Movement Disorder, & TD | Kunen, Seth |
| 8/24/12 | AIMS Movement Disorder Scale and Video; New HEDIS Measures; Staff Evaluation Form | Kunen, Seth |
| 8/27/12 | FAH Workflows | Gonzales, Ricardo |
| 9/7/12 | Outcome Measures & NOMS | Kunen, Seth |
| 9/10/1212 | FAH Workflows | Gonzales, Ricardo |
| 9/12/12 | CFCD Initiative Mock Training | Dixon, Lynelle |
| 9/13/12 | CFCD Initiative Mock Training | Dixon, Lynelle |
| 9/17/12 | Adobe Connect | Dixon, Lynelle; Baskin, Lynn |
| 9/19/12 | Magellan Overview and Clinical Ops | Dixon, Lynelle |
| 9/21/12 | CSoC Referral Form | Mansion, Lloyd |
| 9/24/12 | Crisis Calls and Call Types | Dixon, Lynelle |
| 9/26/12 | Trauma Informed Substance Abuse Treatment for Women | Kunen, Seth |
| 9/27/12 | Intro to iSeries | Dixon, Lynelle |
| 10/2/12 | iSeries Orientation and Intro to IP | Dixon, Lynelle |
| 10/4/12 | iSeries Orientation and Intro to IP | Dixon, Lynelle |
| 10/9/12 | Using the DSM-IV Diagnostic Criteria to Differentiate Between Substance Abuse and Dependence | Brown, Eric |
| 10/10/12 | Performance Mgmt; 2012 Goal Planning & GPS Overview | Gatson, Eboni |

| Date | Title | Facilitator |
|---|---|---|
| 10/16/12 | APA Clinical Practice Guidelines and ASAM | Brown, Eric |
| 10/16/12 | Performance Mgmt; 2012 Goal Planning & GPS Overview | Gatson, Eboni |
| 10/18/12 | MS Outlook Personal Folder Migration | Gatson, Eboni; Hollingsworth, Tom |
| 10/23/12 | Performance Mgmt; 2012 Goal Planning & GPS Overview | Gatson, Eboni |
| 10/24/12 | MS Outlook Personal Folder Migration | Gatson, Eboni; Hollingsworth, Tom |
| 11/1/12 | Clinical Advisor | Hunter, Beverly |
| 11/6/12 | Clinical Practice Guidelines for Depression | Kunen, Seth |
| 11/13/12 | Clinical Practice Guidelines for ADHD | Kunen, Seth |
| 12/11/12 | Clinical Practice Guidelines for Bipolar Disorder | Kunen, Seth |
| 1/28/13 | Superior Customer Service | Dixon, Lynelle |
| 1/29/13 | Superior Customer Service | Dixon, Lynelle |
| 1/30/13 | Superior Customer Service | Dixon, Lynelle |
| 1/31/13 | Superior Customer Service | Dixon, Lynelle |
| 2/1/13 | Superior Customer Service | Dixon, Lynelle |
| 2/4/13 | Superior Customer Service | Dixon, Lynelle |
| 2/5/13 | Superior Customer Service | Dixon, Lynelle |
| 2/8/13 | Assertive Community Treatment | Kunen, Seth |
| 2/26/13 | Superior Customer Service | Dixon, Lynelle |
| 2/27/13 | IBHA and CANS | Dunn, Barbara; Moore, Levillia |
| 2/28/13 | Superior Customer Service | Dixon, Lynelle |
| 3/5/13 | DMAIC | Guarisco, Aaron |
| 3/6/13 | LA Comprehensive CANS: Caregiver Strengths and Needs Domain | Moore, Levillia; Brown, Jocelyn |
| 3/14/13 | Process Updates | Saez, Stacy; White, Angette |
| 3/15/13 | Process Updates | Saez, Stacy; White, Angette |
| 3/19/13 | LA Comprehensive CANS: Youth Risk Domain | Moore, Levillia; Brown, Jocelyn |
| 3/19/13 | PRL/FNC 2013: Overview, PR Plan, Network Expansion Deliverables, IPD, OnBase, DocTracker, Stand Alone Provider Search, CART, Correspondence | Fowler, Gail |
| 3/20/13 | PSH Screening Form | Shavers, Ra'Quel; Schuten, Amy |
| 3/20/13 | PRL/FNC 2013: Credentialing, Contracting Workflows | Fowler, Gail |
| 3/21/13 | PRL/FNC 2013: CA Adds, Claims | Fowler, Gail |

**APPENDIX E: Data Quality Standards**

**Policy and Standards**
**Policy Applicability:**

☑ Behavioral Health (B) ☐ NIA (N) ☐ ICORE (I) ☑ MMA (A) ☐ Physical Health (P) ☐ Magellan Pharmacy Solutions (S)

**Policy:**

| | |
|---|---|
| **Policy Number:** | **Compliance will assign** |
| **Policy Name:** | **Ensuring Timely, Accurate and Complete Reporting** |
| Date of Inception: | |
| Previous Approval Date: | |
| Current Approval Date: | Compliance will assign |

**Policy Approvals:**

| | | |
|---|---|---|
| Neal Cohen | *Approval on file* | |
| General Manager | | Date |
| JoeAnn Coleman | *Approval on file* | |
| Compliance Officer | | Date |
| | *Approval on file* | |
| | | Date |

### Cross Reference(s)

*None*

### Policy Statement

This policy describes the process that governs the Magellan Behavioral Health of Louisiana (Magellan) the reporting of all required RFP deliverables.

### Purpose

The purpose of this policy is to ensure the timely, accurate and complete reporting of all required RFP deliverables by:

1. Verifying the accuracy and timeliness of reported data;
2. Screening data for completeness, logic, and consistency when possible; and

**Policy Terms & Definitions Glossary**

### Standards

I. Data Sources

A. Clinical Advisor (CA) has a number of data entry requirements that ensure data accuracy and completeness. If providers do not enter or verify following data into CA (there are other data confirmation fields in addition to these), they will receive a system prompt to do so:

1. Member name
2. Phone number
3. Effective date coverage began
4. Guarantor (payer)
5. Diagnosis priority
6. Member ID
7. Date copies of information were made
8. Acceptance of assignment of payment
9. Guarantor's relationship to member
10. Therapist's name
11. Clinic location
12. Time of appointment
13. Length of appointment
14. Progress note (verification/review)
15. Enrollment or registration status
16. Correctness of diagnosis
17. Service date
18. Time of service
19. Length of Appointment
20. Accuracy of diagnosis

B. Most Integrated Product (IP) data entry is done by the Care Managers and Member Services Representatives. The Qfiniti Observe automated phone system permits managers of the Care Management and Member Services areas to review the accuracy of the data being entered into IP. Qfiniti Advise provides agent evaluations and Qfiniti Expert is used to develop eLearning modules for our agents to address deficiencies in performance. Member Services Representatives and Care Managers also receive a detailed report card from their managers who review their Qfiniti performance on a monthly basis. The Avaya CMS phone system ensures high data quality by automatically tracking a variety of call performance measures such as number of calls answered, average speed of answer, handle time, and call abandonment rates.

Qfiniti Observe allows supervisors to monitor the phone calls of Member Services Representatives and Care Managers and develop a profile report of their performance. This program gives Magellan supervisors an efficient and effective way to identify deficiencies and develop interventions needed to address data issues. This system also allows a quick search of past recordings based on defined parameters. All customer service supervisors are required to conduct at least five

evaluations per representative each month. Performance results are reviewed on a monthly basis and feedback is provided to each employee in report cards. Employees that score below goal levels are placed on a performance improvement plan created by supervisors.

Appeals data are also entered into IP by the Appeals Coordinator of the Grievance and Appeals department. An independent audit of 100% of the appeals cases is reviewed by an auditor from a separate department for accuracy, completeness, and timeliness. Adherence to specified timeframes for responding to appeals is monitored through an appeals tracking spreadsheet. The spreadsheet contains a number of indicators to ensure that time deadlines are met. The following items are calculated contingent upon date of receipt of request of an appeal:

1. Days until acknowledgement due
2. Acknowledgement due date
3. Date acknowledgement letter is mailed
4. Acknowledgement letter sent beyond due date (days)
5. Days before disposition due
6. Disposition due date
7. Date disposition completed
8. Date Notice of Action of Resolution (NAR) letter mailed
9. Total time to complete resolution

C. The Avaya Call Monitoring System generates the data for the two call performance measures (average speed of answer and call abandonment rates). The Avaya Call Monitoring System (CMS) monitors telephonic transaction of every call that comes in to the Member Service and Care Management departments. Avaya CMS monitors the above performance measures as well as handle time, total calls handled, average call time. These data are electronically collected and analyzed. Reports are presented to the appropriate oversight committees, such as the Quality Improvement Committee and the Magellan Governance Board.

D. The Comment and Resolution Tracking (CART) system monitors the timeframe within which complaints are acknowledged and resolved. Complaints in CART are automatically stamped with date and time indicators that dictate when responses are due. If responses are not entered within these timeframes, staff will receive an alert indicating that a response is overdue. Staff must document in CART when they have fully completed the process of addressing a complaint. A clinical reviewer audits the process involved in resolving five complaints per month. The audits determine whether the grievance process was handled “accurately” by the Complaint Coordinator. Accuracy is determined by matching the elements contained in the complaint file to the items being addressed. The audits involve:

1. Review of the substance of the complaints
2. Assessment of document review process

3. Review of investigation processes, including whether call logs and Clinical Advisor notes were examined and whether there was contact with the provider about the complaint
4. Review of whether all necessary staff were involved in the investigation and resolution
5. Assessment of timeliness of resolution of the complaint
6. A review of the communication to the complainant

E. Claims Adjudication Payment System (CAPS) is used by administrators to examine two percent of all claims for accuracy using the following criteria:

1. Was claim correctly entered into the claims processing system with an assigned transaction number?
2. Was claim associated with the correct provider?
3. Was the service properly authorized?
4. Were the authorization limits exceeded?
5. Was member eligibility correctly applied?
6. Did the payment agree with the contract rate?
7. Is this a duplicate payment for the same claim?
8. Was the denial reason correctly applied?
9. Was co-payment considered and applied?
10. Was the modifier code correctly applied?
11. Was the coding consistent with the provider's credentials?
12. Were adjustments to the claim made properly with supporting documentation?
13. Was payment coordinated properly when other insurance is applicable?

F. Treatment Record Reviews are conducted by the Quality Improvement (QI) department to assess the quality of care provided to members. New roles for the QI department include matching claims to services and conducting assessments of provider fidelity to evidence based practice models. QI conducts inter-rater reliability trainings to ensure the consistency of the clinical reviews. QI tracks the timeliness of Performance Improvement Projects completed by providers, and QM conducts follow up reviews of Formal Performance Improvement Projects to ensure that corrections have been competently implemented. QI tracks the timeliness of the Treatment Record Review Process and turn-around time of Treatment Record Review reports. QI utilizes an internally developed audit tool to monitor the performance of the Wrap-Around-Agencies. The information from this audit tool is compared to data from CA and IP as well as from independent reports generated by the WAAs to ensure accuracy. The Magellan CSoC program also utilizes its own internally generated audit tool to assess compliance with waiver requirements.

II. Quality Improvement Committee (QIC) Structure

The QIC meets monthly to review quality issues presented by the various subcommittees, such as Utilization Management, Race and Equity, RNCC, Member Services, Network, Compliance, and Family Member (FMSAC). This committee is responsible for reviewing reports and ensuring that needed data are presented accurately and in a useful fashion, and that action plans are instituted when needed to improve data quality. The QIC is responsible for ensuring that the following criteria are met for each report presented to the QIC:

A. The source of the reported data is clearly identified and understood.

B. The data are presented in a logical and understandable manner.

C. The data address relevant goals.

D. The data and resultant report are specific enough to support performance improvement actions when indicated.

III. Internal Audits

Data collection and accuracy are assessed by internal audits (e.g., financial audits, Magellan corporate clinical and organizational systems review - SCOR), and external reviews by URAC, DHH-OBH, and External Quality Review Organization).

IV. Reporting Cover Sheets

A. Data reports are expected to conform to the presentation requirements of OBH and Medicaid. The data report cover sheet for each report includes the following information:

1. Date of report
2. Date range of report
3. Author of report
4. Frequency of data aggregation and analysis
5. Methodology
6. Data source
7. Sample size
8. Method of review
9. Performance goal(s)
10. Numerator and denominator, as applicable
11. Results
12. Confidence level
13. Data analyses.

B. Each report is reviewed by a content expert, a supervisor, and quality improvement. Where appropriate, data analyses are verified by a second data analyst prior to distribution of the report.

**APPENDIX F: LA CMC 2013 Cultural Competency Self-Assessment**

This assessment instrument was developed by the Race and Equity Committee for use in Louisiana.

**Multicultural Competence Self-assessment Guide**

Instructions: This cultural competence assessment reflects guidelines developed by various organizations and accrediting bodies. The results of your self-assessment can be used to identify opportunities for improving your agency's cultural competency. Rate your agency on each item in Sections I through VIII using the following scale:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Strongly Disagree | | | | Strongly Agree |

To simplify the writing, "my agency" can refer to a collection of providers or a single provider. Please circle the number that best describes your response to the statements below.

I. Agency Demographic Data (Assessment)

1 2 3 4 5 My agency has identified the demographic characteristics (e.g., gender, race, language) of the geographic area we serve (from recent census data, local planning documents, statement of need, etc).

1 2 3 4 5 My agency has summarized the demographic characteristics of the members we have served and are serving.

1 2 3 4 5 My agency has compared the demographic characteristics of our staff to the demographic characteristics of potential members in our service area.

1 2 3 4 5 My agency has compared the demographic characteristics of our staff to that of the members we serve.

II. Policies, Procedures and Governance

1 2 3 4 5 My agency has a Cultural Competence Plan.

1 2 3 4 5 My agency has appointed executives, managers and administrators who take responsibility for, and have authority over, the development, implementation, and monitoring of the Cultural Competence Plan.

1 2 3 4 5 My agency's director has appointed a standing committee to advise management on matters pertaining to multicultural services.

1 2 3 4 5 My agency has a mission statement that commits to cultural competence and reflects compliance with all federal and state statutes, as well as any current State or local discriminatory and affirmative action policies.

1 2 3 4 5 My agency has culturally appropriate policies and procedures communicated orally and/or written in the preferred language of our members. These policies and procedures address member rights (such as confidentiality, freedom of choice, and grievance procedures).

III. Services/Programs:

A. Linguistic and Communication Support:

1 2 3 4 5 My agency provides (or can provide) materials and services (e.g., bilingual staff, in-house interpreters, or a contract with outside interpreter agency and/or telephone interpreters) in the preferred languages of our members.

1 2 3 4 5 My agency's records document the preferred language of each member.

1 2 3 4 5 My agency has a protocol to handle complaints in the preferred languages of the members.

1 2 3 4 5 My agency provides forms in the preferred languages of the members.

1 2 3 4 5 Staff at my agency who answer telephones are able to communicate in the preferred language of the caller or they are able to refer the caller to someone who can communicate in the caller's preferred language.

1 2 3 4 5 My agency has signs posted at key locations that explain what language assistance we have available.

1 2 3 4 5 My agency has a protocol that is provided to members that explains, in the preferred languages of the members, complaint procedures.

1 2 3 4 5 My agency provides cultural and linguistic supports for members throughout the service continuum. (Such as special protocols for addressing language issues at the emergency room, treatment rooms, intake, etc.)

B. Treatment/Rehabilitation Planning

1 2 3 4 5 My agency considers the members' culture, ethnicity and language in treatment planning (assessment of needs, diagnosis, medications, interventions, discharge planning, etc.).

1 2 3 4 5 My agency involves members and their families/significant others in all phases of treatment, assessment and discharge planning.

1 2 3 4 5 My agency has identified natural supports (relatives, traditional healers, spiritual resources, etc.) for helping members reintegrating into the community.

C. Cultural Assessments

1 2 3 4 5 My agency has a protocol that addresses complaints in the preferred languages of the members.

1 2 3 4 5 My agency uses a member centered approach when formulating diagnoses and treatment plans that reflects the members' cultural and demographic characteristics and needs.

1 2 3 4 5 My agency uses culturally relevant assessment tools utilized in the assessment process.

1 2 3 4 5 My agency identifies the member's level of acculturation and incorporates that knowledge in the assessment process.

D. Cultural Accommodations

1 2 3 4 5 My agency utilizes culturally appropriate educational material such as films, slide presentations or video tapes when orienting members/families to our program.

1 2 3 4 5 My agency has ethnic/culture-specific group formats available for engagement, treatment and/or rehabilitation.

1 2 3 4 5 My agency collaborates with natural community healers, spiritual healers, clergy, etc., where appropriate, in the development and/or implementation of the service plan.

E. Program Accessibility

1 2 3 4 5 Members from different cultural and linguistic backgrounds have equal access to services

1 2 3 4 5 My agency provides services that are located close to the neighborhoods where members from different cultures and linguistic backgrounds reside.

1 2 3 4 5 My agency can be readily accessed by those who use public transportation.

1 2 3 4 5 My agency provides needed supports to families of members (e.g., meeting rooms for extended families, child support, and drop-in services).

1 2 3 4 5 My agency has services available during evenings and weekends.

IV. Care Management

1 2 3 4 5 The level of care and length of services provided meet the needs of members from different cultural backgrounds.

1 2 3 4 5 The type of care our agency provides to members from different backgrounds consistently and effectively addresses their identified cultural needs.

1 2 3 4 5 The services we provide for people from different groups is compatible with their ethnic/cultural background.

V. Continuity of Care

1 2 3 4 5 My agency has letters of agreement with culturally oriented community services and organizations.

1 2 3 4 5 My agency has integrated, planned, transitional arrangements between service levels (i.e., we have continuity of care plans in place).

1 2 3 4 5 My agency has arrangements (financial or otherwise) for securing services needed by members (e.g., housing, income, employment, medical, and transportation).

VI. Human Resources Development

1 2 3 4 5 My agency includes in staff orientation and training principles of cultural competence (e.g., cultural awareness, language training skills training in working with diverse populations).

1 2 3 4 5 My agency uses other programs or organizations that specialize in serving members with diverse cultural and linguistic backgrounds as a resource for staff education and training.

1 2 3 4 5 My agency makes a consistent effort to recruit and retain staff who reflect the cultural and linguistic diversity of our members.

1 2 3 4 5 My agency has a procedure in place for assessing the cultural competency of our staff.

1 2 3 4 5 The majority of our staff has attended training programs on cultural competence in the past two years.

Describe: _____

_____

VII. Quality Monitoring and Improvement

1 2 3 4 5 My agency has a Quality Improvement Plan that addresses the cultural/ethnic and language needs of our members.

1 2 3 4 5 My agency has a multicultural advisory committee.

1 2 3 4 5 My agency maintains copies of minutes, recommendations, and accomplishments of our multicultural advisory committee.

VIII. Information/Management System

1 2 3 4 5 My agency has a quality management plan that addresses patient safety, clinical outcomes, use of evidence based practices, and implementation of cultural competent services.

1 2 3 4 5 My agency employs member satisfaction surveys.

1 2 3 4 5 My agency uses member satisfaction surveys available in the preferred languages of our members.

Summarizing and Applying Assessment Findings

To interpret this instrument, review your responses and note areas that represent your agency's strengths (#4 & #5), improvement needed areas, (# 3) and priority concern areas (#1 & #2).

Your pattern of responses provides you with an overall picture of possible intervention areas that can help to enhance your agency's level of cultural and linguistic competence.

Findings of this assessment can be used to inform the development of an agency cultural competence plan.

To develop a plan based on your assessment findings, use the Cultural Competence Plan Template included in this resource kit. This template outlines goals/objectives, action steps, person/persons responsible, timeframes, outcomes and strategies for measuring progress. Strategies for completing the template and developing an agency cultural competence plan are

included with the template.  An example of a completed template and an agency cultural competence plan is included in this resource kit.

**Appendix G. Provider Density by Parrish**

| County | State | Members | Prescriber Goal | Prescriber Actual | Non-Prescriber Goal | Non-Prescriber Actual |
|---|---|---|---|---|---|---|
| Cameron | LA | 484 | 0.1 | 0 | 0.4 | 0 |
| Tensas | LA | 1670 | 0.3 | 0 | 1.3 | 1 |
| West Feliciana | LA | 2014 | 0.4 | 0 | 1.6 | 1 |
| St. Helena | LA | 2177 | 0.4 | 0 | 1.7 | 2 |
| Red River | LA | 2698 | 0.5 | 1 | 2.2 | 0 |
| La Salle | LA | 2759 | 0.6 | 1 | 2.2 | 2 |
| Caldwell | LA | 2883 | 0.6 | 0 | 2.3 | 0 |
| East Carroll | LA | 3068 | 0.6 | 0 | 2.5 | 0 |
| Jackson | LA | 3303 | 0.7 | 0 | 2.6 | 3 |
| West Carroll | LA | 3319 | 0.7 | 0 | 2.7 | 0 |
| Catahoula | LA | 3427 | 0.7 | 0 | 2.7 | 1 |
| Claiborne | LA | 3607 | 0.7 | 0 | 2.9 | 0 |
| Winn | LA | 3735 | 0.7 | 0 | 3.0 | 1 |
| Bienville | LA | 3902 | 0.8 | 0 | 3.1 | 1 |
| Madison | LA | 4180 | 0.8 | 0 | 3.3 | 7 |
| East Feliciana | LA | 4845 | 1.0 | 4 | 3.9 | 30 |
| St. James | LA | 5028 | 1.0 | 0 | 4.0 | 1 |
| West Baton Rouge | LA | 5096 | 1.0 | 0 | 4.1 | 0 |
| Grant | LA | 5127 | 1.0 | 0 | 4.1 | 2 |
| Assumption | LA | 5144 | 1.0 | 0 | 4.1 | 0 |
| Plaquemines | LA | 5210 | 1.0 | 0 | 4.2 | 4 |
| Concordia | LA | 5455 | 1.1 | 0 | 4.4 | 1 |
| Sabine | LA | 5544 | 1.1 | 0 | 4.4 | 6 |
| Pointe Coupee | LA | 5579 | 1.1 | 0 | 4.5 | 7 |
| Union | LA | 5580 | 1.1 | 0 | 4.5 | 0 |
| Allen | LA | 5905 | 1.2 | 0 | 4.7 | 2 |
| Richland | LA | 6402 | 1.3 | 0 | 5.1 | 10 |
| Franklin | LA | 6486 | 1.3 | 1 | 5.2 | 4 |
| De Soto | LA | 6551 | 1.3 | 0 | 5.2 | 5 |
| Jefferson Davis | LA | 7526 | 1.5 | 4 | 6.0 | 8 |
| Beauregard | LA | 8143 | 1.6 | 1 | 6.5 | 6 |
| Iberville | LA | 8786 | 1.8 | 0 | 7.0 | 2 |
| Morehouse | LA | 9211 | 1.8 | 0 | 7.4 | 1 |
| Lincoln | LA | 9220 | 1.8 | 3 | 7.4 | 20 |
| Vernon | LA | 9334 | 1.9 | 1 | 7.5 | 3 |
| St. Charles | LA | 9780 | 2.0 | 2 | 7.8 | 8 |
| Evangeline | LA | 9834 | 2.0 | 18 | 7.9 | 2 |
| Webster | LA | 10637 | 2.1 | 0 | 8.5 | 10 |
| Natchitoches | LA | 10995 | 2.2 | 1 | 8.8 | 12 |

| | | | | | | |
|---|---|---|---|---|---|---|
| St. Martin | LA | 12154 | 2.4 | 3 | 9.7 | 13 |
| St. John the Baptist | LA | 12656 | 2.5 | 1 | 10.1 | 16 |
| Avoyelles | LA | 12831 | 2.6 | 1 | 10.3 | 5 |
| Vermilion | LA | 12924 | 2.6 | 2 | 10.3 | 1 |
| Washington | LA | 13800 | 2.8 | 1 | 11.0 | 9 |
| St. Bernard | LA | 14276 | 2.9 | 0 | 11.4 | 29 |
| St. Mary | LA | 16053 | 3.2 | 0 | 12.8 | 18 |
| Acadia | LA | 17784 | 3.6 | 8 | 14.2 | 12 |
| Bossier | LA | 19955 | 4.0 | 3 | 16.0 | 8 |
| Ascension | LA | 20056 | 4.0 | 8 | 16.0 | 17 |
| Lafourche | LA | 20550 | 4.1 | 3 | 16.4 | 10 |
| Iberia | LA | 20578 | 4.1 | 1 | 16.5 | 12 |
| Livingston | LA | 25365 | 5.1 | 0 | 20.3 | 21 |
| Terrebonne | LA | 27795 | 5.6 | 10 | 22.2 | 43 |
| St. Landry | LA | 28680 | 5.7 | 5 | 22.9 | 12 |
| Tangipahoa | LA | 35498 | 7.1 | 7 | 28.4 | 44 |
| Rapides | LA | 35586 | 7.1 | 16 | 28.5 | 60 |
| St. Tammany | LA | 38260 | 7.7 | 26 | 30.6 | 99 |
| Lafayette | LA | 41643 | 8.3 | 25 | 33.3 | 124 |
| Ouachita | LA | 42077 | 8.4 | 12 | 33.7 | 76 |
| Calcasieu | LA | 44593 | 8.9 | 21 | 35.7 | 54 |
| Caddo | LA | 64983 | 13.0 | 32 | 52.0 | 87 |
| East Baton Rouge | LA | 98185 | 19.6 | 49 | 78.5 | 213 |
| Jefferson | LA | 113399 | 22.7 | 24 | 90.7 | 141 |
| Orleans | LA | 117642 | 23.5 | 47 | 94.1 | 219 |
| Total | | 1121967 | 224.4 | 342 | 897.6 | 1506 |