



**MAGELLAN HEALTH**

**QUALITY IMPROVEMENT – CLINICAL / UTILIZATION MANAGEMENT**

**PROGRAM EVALUATION**

**FOR**

**Behavioral Health Division**  
*Louisiana Unit*

**March 1, 2015-November 30, 2015**

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**EXECUTIVE SUMMARY**

The Magellan Health (Magellan) Louisiana Unit conducts an annual evaluation of its Quality Improvement Program to evaluate outcomes; review effectiveness; assess goal achievement; evaluate the deployment of resources; document and trend input from advisory groups, including members, family members and other stakeholders; and to identify opportunities for improvement in the ongoing provision of safe, high-quality care and service to members. The evaluation covers a fully integrated quality program including recovery/resiliency-focused clinical and medical integration programs. This report summarizes the evaluation findings from the Louisiana Unit data from March 1, 2015 through November 30, 2015. In addition, this report assesses progress towards the goals and prioritized objectives set forth in the previous year’s Louisiana Unit quality improvement program description, work plan and program evaluation helping to insure that the spirit of the Louisiana Unit’s mission is realized. This is the final program evaluation for the Magellan’s Louisiana Behavioral Health Partnership (LBHP) contract. The state of Louisiana integrated behavioral health and substance use services into the Bayou Health Plans (MCOs) on December 1, 2015.

The Program Evaluation is an internal practical document used by Magellan of Louisiana to analyze its current status compared to performance and program goals, identify barriers or challenges as well as opportunities for improvement, and develop interventions to improve or promote care and service to the populations served. This document is not written for public consumption, but to facilitate collaborative initiatives with our customer and across the contracted populations. The Program Evaluation supports requirements outlined in the State’s Quality Improvement Strategy and provides a summary of the prior year’s initiatives.

**Key Accomplishments**

Key accomplishments of Magellan in Louisiana since implementation of the contract in March 1, 2012:

- Successful management of processes to address the following activities (as presented in the September 2015 Business Review):

<b>Event</b>	<b>Volume</b>
Inbound Calls Answered	415,000
Authorizations Completed	919,000
Completed Peer Reviews	20,949
Adverse Incidents	1094
Quality of Care Concerns	1071
Community Outreach Events	1300

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<b>Event</b>	<b>Volume</b>
Miles Logged	473,784
FWA Allegations	200+
FWA Recoupment Dollars	\$560k

- Successful management of quality program, work plan, and initiatives
- Strong collaboration and successful transition of the LBHP population to the Bayou Health Plans

**ACKNOWLEDGMENT AND APPROVAL**

The 2015 Quality Improvement and Utilization Management Program Evaluation was prepared by the Louisiana Unit and submitted to the Louisiana Department of Health and Hospitals Office of Behavioral Health:

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Date**

Neal Cohen,  
Chief Executive Officer and Chief Operating Officer

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Date**

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

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**I. OVERVIEW**

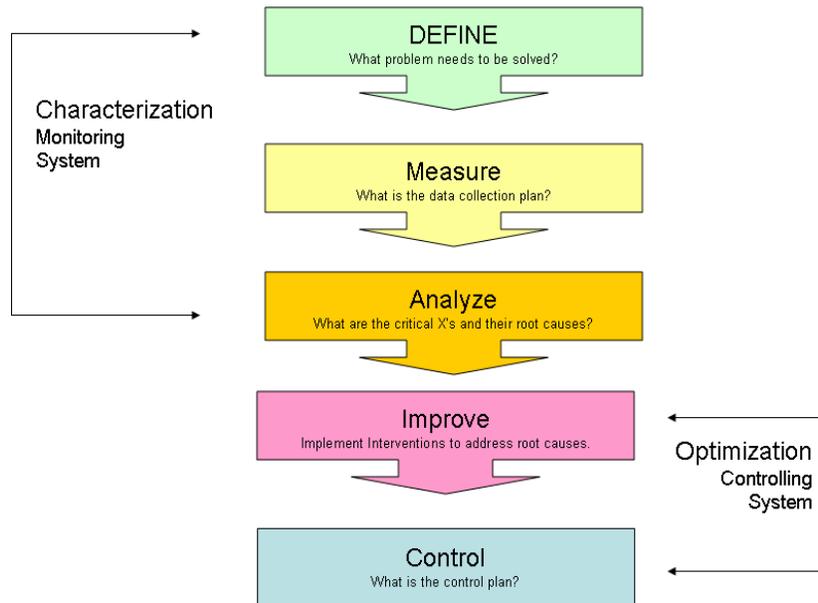
The Magellan Healthcare (Magellan) Louisiana Unit manages mental health/substance use services in a variety of settings delivered by providers from several disciplines. The lines of business served by the Magellan Louisiana Unit include Medicaid coverage and populations identified as part of the Louisiana Behavioral Health Partnership (LBHP). The LBHP includes the Office of Behavioral Health (OBH), the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ), the Department of Education (DOE), and Medicaid. The Louisiana Unit's quality program is comprehensive and covers the following product lines: Behavioral Health Care Management and Recovery and Resiliency Care Management. In addition, the Louisiana Unit manages the Coordinated System of Care (CSoC) programs for eligible members. Magellan managed these lines of business through an emergency contract with OBH that expired on November 30, 2015. On December 1, 2015, Louisiana's medical health plans, known as Bayou Health Plans, became responsible for the management of specialized behavioral health services. Magellan will continue management of the Coordinated System of Care (CSoC) program until November 30, 2017 or as directed by OBH and Medicaid.

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

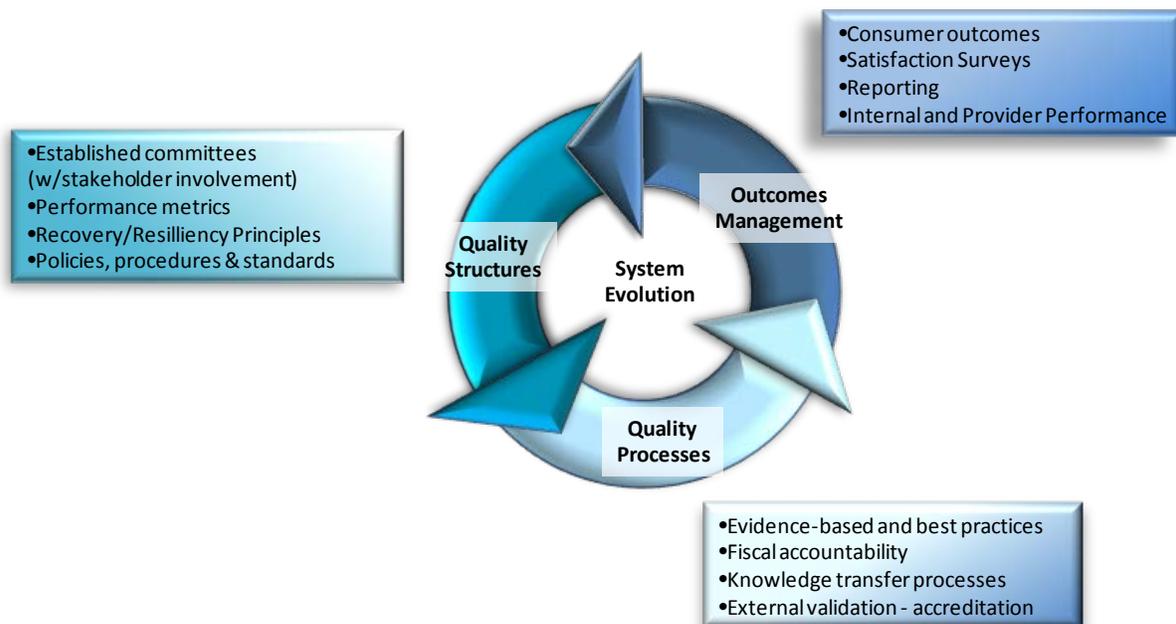
**Quality Process at the Louisiana Care Management Center**

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

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



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

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

Magellan conducts an annual population assessment to provide a review of the Louisiana Behavioral Health Partnership (LBHP) members in order to enable the Louisiana Unit to make informed improvements and/or enhancements to ongoing and planned quality and service initiatives and programs. As part of the overall goal to maintain and enhance the quality of service provided to the Louisiana Unit members, the Quality Improvement Department amasses data from a variety of sources to develop a comprehensive enrollee population assessment each year. The assessment evaluates member demographics, provider network demographics, and cultural competency program. This can be used to provide information to inform future contractors regarding population and provider characteristics for the Medicaid and non-Medicaid members of the state of Louisiana.

**A. Member Demographic**

This section provides a demographic analysis of the members served by the Louisiana Unit. It serves as a mechanism to better understand Louisiana Unit members' characteristics to ensure services are in place to adequately meet the needs of the members. The primary data source for member demographics is the Medicaid eligibility feed; however, multiple data sources are utilized to ensure the most complete data set are available, including Caps Adjudication Payment System (CAPS), Integrated Product (IP), and Clinical Advisor (CA) feeds. The time parameter is 8/1/2014 - 7/31/2015 and comparisons are given for 8/1/2013 - 7/31/2014. Analysis focuses on the Medicaid eligible population, as it represents a majority of the membership; although, non-Medicaid and unknown populations are presented as well for reference. Please see **Section VIII Evaluation of Over/Under Utilization of Services** for a more detailed analysis of utilization by level of care. The following list of the demographic variables is analyzed within this section:

- Population
- Age
- Gender
- Veteran Status
- Regions

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- Top mental health diagnoses for age groups
- Race/Ethnicity

**Population**

This number accounts for all populations served under the LBHP, including Medicaid and non-Medicaid populations. There was 0.9% growth in the number of eligible members from 2014 to 2015. The percent of members based on eligibility from 2014 to 2015 showed minimal changes. The penetration rate is the number of members who received services divided by the number of members eligible. There were no notable changes in the penetration or membership from 2014 to 2015, with overall rate changes equaling less than a percentage point. The eligibility percentages can be seen in the chart below.

		8/1/2013 - 7/31/2014				8/1/2014 - 7/31/2015			
Medicaid Status	Gender	N_Members	Prevalence	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Medicaid	Total	1,194,519	82.1%	127,154	75.9%	1,217,949	80.0%	138,052	82.0%
Non-Medicaid	Total	286,421	19.6%	38,693	23.1%	343,636	22.5%	28,068	16.6%
Unknown	Total	5,477	.3%	5,477	3.2%	4,396	.2%	4,396	2.6%
Total	Total	1,454,407*	100%*	167,380*	100%*	1,521,616*	100%*	168,254*	100%*

*\*While only unique members were counted, some members were in more than one of the Medicaid Status categories during the time period and are represented in each applicable category. This explains why the Totals are < the sum of the three categories and why the percentages may be >100%.*

**Age**

Medicaid groups members into two major age categories. The youth category represents members between zero and 21, and the adult category represents members over 21. The penetration rate for Medicaid youth members was 10.0%, or 86,550 served of the 858,755 eligible members, an increase of 1.3% from 2014. Medicaid adults had a penetration rate of 14.5%, or 55,526 served of the 382,634 eligible members. There were not notable changes in the penetration or membership based on age from 2014 to 2015. The 0-17 age categories showed some elevation in representation in the members served.

The group with the greatest disparity between those eligible and served continues to be the children 0-5 group. This group represented a percentage of 5.01% of the members served despite representing a percentage of 23.94% for the Medicaid eligible population. Although national percentages are not specific to this age group, many diagnoses outside of neurodevelopmental disorders cannot be made

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until at least the age of 3. This may explain the lower number of members served. Magellan does recognize the importance of ensuring providers have the necessary training to treat this unique and vulnerable population. Magellan has partnered with Louisiana State University and Tulane University to provide special training on two evidence-based practices, Child-Parent Psychotherapy (CPP), and Parent Management Training, to ensure providers have the required skills to treat this age group. More details on this initiative can be found in **Section XVI Evidence- and Best Practice Initiatives**.

		8/1/2013 - 7/31/2014				8/1/2014 - 7/31/2015			
Medicaid Status	Age Group	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Medicaid	0 - 5	290,844	24.35%	5,567	4.38%	291,603	23.94%	6,911	5.01%
Medicaid	6 - 12	289,605	24.24%	33,293	26.18%	299,539	24.59%	40,636	29.44%
Medicaid	13 - 17	179,777	15.05%	27,017	21.25%	186,943	15.35%	31,644	22.92%
Medicaid	18 - 21	75,308	6.30%	6,825	5.37%	80,670	6.62%	7,359	5.33%
Medicaid	22 - 64	300,271	25.14%	49,942	39.28%	301,964	24.79%	48,167	34.89%
Medicaid	65+	58,714	4.92%	4,510	3.55%	57,230	4.70%	3,335	2.42%
Medicaid	Total	1,194,519	100.00%	127,154	100.00%	1,217,949	100.00%	138,052	100.00%
Non-Medicaid	0 - 5	2,608	0.91%	42	0.11%	3,025	0.88%	33	0.12%
Non-Medicaid	6 - 12	1,893	0.66%	155	0.40%	2,105	0.61%	118	0.42%
Non-Medicaid	13 - 17	2,060	0.72%	413	1.07%	2,209	0.64%	361	1.29%
Non-Medicaid	18 - 21	25,483	8.90%	2,055	5.31%	35,341	10.28%	1,568	5.59%
Non-Medicaid	22 - 64	227,009	79.26%	34,892	90.18%	269,875	78.54%	25,136	89.55%
Non-Medicaid	65+	27,368	9.56%	1,136	2.94%	31,081	9.04%	852	3.04%
Non-Medicaid	Total	286,421	100.00%	38,693	100.00%	343,636	100.00%	28,068	100.00%
Unknown	Unknown	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Unknown	Total	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Total	Total	1,454,407		167,380		1,521,616		168,254	

**Gender**

There were little changes in the gender percentages between calendar years 2014 and 2015. The female gender represented 56.95% of the Medicaid eligible population, with the male gender representing 43.05%. In 2015, there were slight improvements in the penetration rates for both males and females with 10.4% of eligible female members being served by the LBHP (9.9% in 2014) and 12.5% of eligible males being served (11.6% in 2014).

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		8/1/2013 - 7/31/2014				8/1/2014 - 7/31/2015			
Medicaid Status	Gender	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Medicaid	Female	674,822	56.49%	66,904	52.62%	693,636	56.95%	72,528	52.54%
Medicaid	Male	519,669	43.50%	60,248	47.38%	524,282	43.05%	65,521	47.46%
Medicaid	Unknown	28	0.00%	2	0.00%	31	0.00%	3	0.00%
Medicaid	Total	1,194,519	100.00%	127,154	100.00%	1,217,949	100.00%	138,052	100.00%
Non-Medicaid	Female	180,642	63.07%	17,340	44.81%	209,552	60.98%	12,172	43.37%
Non-Medicaid	Male	97,294	33.97%	18,742	48.44%	125,603	36.55%	14,272	50.85%
Non-Medicaid	Unknown	8,485	2.96%	2,611	6.75%	8,481	2.47%	1,624	5.79%
Non-Medicaid	Total	286,421	100.00%	38,693	100.00%	343,636	100.00%	28,068	100.00%
Unknown	Female	1,423	25.98%	1,423	25.98%	922	20.97%	922	20.97%
Unknown	Male	1,618	29.54%	1,618	29.54%	791	17.99%	791	17.99%
Unknown	Unknown	2,436	44.48%	2,436	44.48%	2,683	61.03%	2,683	61.03%
Unknown	Total	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Total	Total	1,454,407		167,380		1,521,616		168,254	

**Veteran Status**

The data for veteran status is not a required field in Medicaid eligibility and therefore depended on self-report to collect data. Because of this, 99% of data regarding veteran status were unknown. In 2015, a majority of the members served in 2014 were non-veterans (99.46%), which is consistent with 2014. It is believed number of veterans served was low because they access service through other avenues (e.g., Veterans Administration providers).

		8/1/2013 - 7/31/2014				8/1/2014 - 7/31/2015			
Medicaid Status	Veteran Status	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Medicaid	No	37,624	3.15%	37,624	29.59%	16,493	1.35%	16,493	11.95%
Medicaid	Yes	332	0.03%	332	0.26%	89	0.01%	89	0.06%
Medicaid	Unknown	1,193,021	99.87%	125,186	98.45%	1,217,118	99.93%	137,019	99.25%
Medicaid	Total	1,194,519	100.00%	127,154	100.00%	1,217,949	100.00%	138,052	100.00%
Non-Medicaid	No	15,582	5.44%	15,582	40.27%	5,485	1.60%	5,485	19.54%
Non-Medicaid	Yes	595	0.21%	595	1.54%	230	0.07%	230	0.82%
Non-Medicaid	Unknown	279,281	97.51%	31,020	80.17%	341,604	99.41%	25,841	92.07%
Non-Medicaid	Total	286,421	100.00%	38,693	100.00%	343,636	100.00%	28,068	100.00%
Unknown	No	2,821	51.51%	2,821	51.51%	1,435	32.64%	1,435	32.64%

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Unknown	Yes	81	1.48%	81	1.48%	73	1.66%	73	1.66%
Unknown	Unknown	2,725	49.75%	2,725	49.75%	3,062	69.65%	3,062	69.65%
Unknown	Total	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Total	Total	1,454,407		167,380		1,521,616		168,254	

**Data by Region**

Regional data supported that most of the regions were adequately represented in the members served population.

Medicaid Status	Region	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Medicaid	Acadiana Human Services District	156,187	13.08%	13,593	10.69%	160,139	13.15%	15,122	10.95%
Medicaid	Capitol Area Human Service District	155,427	13.01%	16,414	12.91%	158,805	13.04%	17,965	13.01%
Medicaid	Central Louisiana Human Services District	83,289	6.97%	8,045	6.33%	84,988	6.98%	9,235	6.69%
Medicaid	Florida Parishes Human Service Authority	128,282	10.74%	14,736	11.59%	131,722	10.82%	16,450	11.92%
Medicaid	Imperial Calcasieu Human Service Authority	73,846	6.18%	8,021	6.31%	75,494	6.20%	8,400	6.08%
Medicaid	Jefferson Parish Human Service Authority	101,450	8.49%	12,089	9.51%	106,009	8.70%	12,815	9.28%
Medicaid	Metropolitan Human Service District	120,269	10.07%	15,521	12.21%	123,536	10.14%	16,662	12.07%
Medicaid	Northeast Delta Human Services District	104,403	8.74%	11,935	9.39%	106,926	8.78%	13,496	9.78%
Medicaid	Northwest Louisiana Human Services District	142,806	11.96%	13,090	10.29%	147,543	12.11%	14,660	10.62%
Medicaid	South Central Louisiana Human Service Authority	99,617	8.34%	11,042	8.68%	102,037	8.38%	11,474	8.31%
Medicaid	Unknown	29,095	2.44%	2,815	2.21%	20,793	1.71%	1,815	1.31%
Medicaid	Total	1,194,519	100.00%	127,154	100.00%	1,217,949	100.00%	138,052	100.00%
Non-Medicaid	Acadiana Human Services District	26,628	9.30%	3,846	9.94%	35,232	10.25%	3,540	12.61%
Non-Medicaid	Capitol Area Human Service District	32,706	11.42%	3,795	9.81%	42,140	12.26%	1,671	5.95%
Non-Medicaid	Central Louisiana Human Services District	18,422	6.43%	2,870	7.42%	22,970	6.68%	2,515	8.96%
Non-Medicaid	Florida Parishes Human Service Authority	26,771	9.35%	4,157	10.74%	34,166	9.94%	3,980	14.18%
Non-Medicaid	Imperial Calcasieu Human Service Authority	15,003	5.24%	2,210	5.71%	19,729	5.74%	940	3.35%
Non-Medicaid	Jefferson Parish Human Service Authority	39,397	13.75%	4,682	12.10%	39,346	11.45%	3,512	12.51%

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Medicaid Status	Region	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Non-Medicaid	Metropolitan Human Service District	51,120	17.85%	4,555	11.77%	52,583	15.30%	2,368	8.44%
Non-Medicaid	Northeast Delta Human Services District	21,518	7.51%	3,458	8.94%	28,333	8.25%	2,830	10.08%
Non-Medicaid	Northwest Louisiana Human Services District	24,208	8.45%	2,763	7.14%	33,465	9.74%	1,447	5.16%
Non-Medicaid	South Central Louisiana Human Service Authority	24,780	8.65%	6,007	15.52%	30,464	8.87%	4,998	17.81%
Non-Medicaid	Unknown	5,922	2.07%	398	1.03%	5,225	1.52%	284	1.01%
Non-Medicaid	Total	286,421	100.00%	38,693	100.00%	343,636	100.00%	28,068	100.00%
Unknown	Acadiana Human Services District	555	10.13%	555	10.13%	466	10.60%	466	10.60%
Unknown	Capitol Area Human Service District	541	9.88%	541	9.88%	204	4.64%	204	4.64%
Unknown	Central Louisiana Human Services District	169	3.09%	169	3.09%	313	7.12%	313	7.12%
Unknown	Florida Parishes Human Service Authority	351	6.41%	351	6.41%	368	8.37%	368	8.37%
Unknown	Imperial Calcasieu Human Service Authority	425	7.76%	425	7.76%	132	3.00%	132	3.00%
Unknown	Jefferson Parish Human Service Authority	286	5.22%	286	5.22%	169	3.84%	169	3.84%
Unknown	Metropolitan Human Service District	332	6.06%	332	6.06%	129	2.93%	129	2.93%
Unknown	Northeast Delta Human Services District	235	4.29%	235	4.29%	379	8.62%	379	8.62%
Unknown	Northwest Louisiana Human Services District	306	5.59%	306	5.59%	95	2.16%	95	2.16%
Unknown	South Central Louisiana Human Service Authority	209	3.82%	209	3.82%	540	12.28%	540	12.28%
Unknown	Unknown	2,219	40.51%	2,219	40.51%	1,735	39.47%	1,735	39.47%
Unknown	Total	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Total	Total	1,454,407		167,380		1,521,616		168,254	

**Diagnostic Prevalence**

The Louisiana Unit evaluated diagnostic prevalence for inpatient and outpatient levels of care. Because inpatient level of care provides care for higher acuity levels, it was believed that level of care was a confounding variable that could extraneously affect the data; thus, inpatient and outpatient level of cares were analyzed separately. DSM-IV coding was used in this analysis. DSM 5/ICD-10 coding was fully implemented for the Louisiana Unit in October 2015.

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Depressive disorders accounted for the majority of the top ten inpatient diagnoses for all age groups, which was consistent with previous years. Schizophrenia and other psychotic disorders were also highly represented in the adult populations for inpatient diagnoses. ADHD accounted for a majority of the top ten outpatient diagnoses for the 0-21 population. The Louisiana Unit monitors Clinical Practice Guidelines (CPGs) for Schizophrenia, Depressive Disorders, ADHD, and Suicide Risk while conducting Treatment Record Reviews to ensure compliance with best treatment practices for these diagnoses. Please see **Section XIV Treatment Record Reviews and Clinical Practice Guidelines** for results of the CPG monitoring.

**Top Ten Inpatient Diagnoses**

Diagnosis	N_Members	N_Members Served	% of N_Members	% of Top 10 Diagnoses
<b>8/1/2014 - 7/31/2015 Inpatient Medicaid 0 - 21 Age Group</b>				
311.00-Depressive disorder, not elsewhere classified	858,755	3,328	0.39%	30.24%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	858,755	2,406	0.28%	21.86%
296.90-AFFECTIVE PSYCHOSIS	858,755	1,554	0.18%	14.12%
296.80-Bipolar disorder, unspecified	858,755	872	0.10%	7.92%
298.90-Unspecified psychosis	858,755	583	0.07%	5.30%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	858,755	573	0.07%	5.21%
296.23-Major depressive affective disorder, single episode, severe, without mention of psychotic behavior	858,755	533	0.06%	4.84%
312.30-IMPULSE CONTROL DISORDER	858,755	457	0.05%	4.15%
312.34-Intermittent explosive disorder	858,755	377	0.04%	3.43%
314.90-Unspecified hyperkinetic syndrome	858,755	322	0.04%	2.93%
<b>8/1/2014 - 7/31/2015 Inpatient Medicaid 22+ Age Group</b>				
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	359,194	2,898	0.81%	17.81%
295.70-SCHIZOAFFECTIVE	359,194	2,211	0.62%	13.59%
298.90-Unspecified psychosis	359,194	1,894	0.53%	11.64%
311.00-Depressive disorder, not elsewhere classified	359,194	1,746	0.49%	10.73%
295.90-SCHIZOPHRENIA NOS	359,194	1,433	0.40%	8.81%
295.30-PARANOID SCHIZOPHRENIA	359,194	1,347	0.38%	8.28%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	359,194	1,294	0.36%	7.95%
296.80-Bipolar disorder, unspecified	359,194	1,199	0.33%	7.37%
295.34-Paranoid type schizophrenia, chronic with acute exacerbation	359,194	1,179	0.33%	7.25%
295.74-Schizoaffective disorder, chronic with acute exacerbation	359,194	1,067	0.30%	6.56%
<b>8/1/2014 - 7/31/2015 Inpatient Non-Medicaid 0 - 21 Age Group</b>				
311.00-Depressive disorder, not elsewhere classified	42,680	78	0.18%	40.00%

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Diagnosis	N_Members	N_Members Served	% of N_Members	% of Top 10 Diagnoses
298.90-Unspecified psychosis	42,680	31	0.07%	15.90%
296.90-AFFECTIVE PSYCHOSIS	42,680	21	0.05%	10.77%
296.80-Bipolar disorder, unspecified	42,680	18	0.04%	9.23%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	42,680	16	0.04%	8.21%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	42,680	9	0.02%	4.62%
295.90-SCHIZOPHRENIA NOS	42,680	8	0.02%	4.10%
295.30-PARANOID SCHIZOPHRENIA	42,680	5	0.01%	2.56%
296.70-Bipolar I disorder, most recent episode (or current) unspecified	42,680	5	0.01%	2.56%
296.30-Major depressive affective disorder, recurrent episode, unspecified	42,680	4	0.01%	2.05%
<b>8/1/2014 - 7/31/2015 Inpatient Non-Medicaid 22+ Age Group</b>				
311.00-Depressive disorder, not elsewhere classified	300,956	831	0.28%	34.61%
298.90-Unspecified psychosis	300,956	356	0.12%	14.83%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	300,956	291	0.10%	12.12%
296.80-Bipolar disorder, unspecified	300,956	199	0.07%	8.29%
296.90-AFFECTIVE PSYCHOSIS	300,956	172	0.06%	7.16%
295.70-SCHIZOAFFECTIVE	300,956	168	0.06%	7.00%
295.90-SCHIZOPHRENIA NOS	300,956	149	0.05%	6.21%
295.30-PARANOID SCHIZOPHRENIA	300,956	94	0.03%	3.92%
296.70-Bipolar I disorder, most recent episode (or current) unspecified	300,956	72	0.02%	3.00%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	300,956	69	0.02%	2.87%

**Top Ten Outpatient Diagnostic Categories**

Diagnosis	N_Members	N_Members Served	% of N_Members	% of Top 10 Diagnoses
<b>8/1/2014 - 7/31/2015 Outpatient Medicaid 0 - 21 Age Group</b>				
314.01-Attention deficit disorder with hyperactivity	858,755	43,832	5.10%	45.33%
313.81-Oppositional defiant disorder	858,755	12,433	1.45%	12.86%
311.00-Depressive disorder, not elsewhere classified	858,755	8,719	1.02%	9.02%
314.00-ATTENTION DEFICIT DISORDER	858,755	7,347	0.86%	7.60%
312.90-Unspecified disturbance of conduct	858,755	4,910	0.57%	5.08%
309.90-Unspecified adjustment reaction	858,755	4,380	0.51%	4.53%
300.00-ANXIETY STATE	858,755	4,018	0.47%	4.16%
296.90-AFFECTIVE PSYCHOSIS	858,755	3,943	0.46%	4.08%
314.90-Unspecified hyperkinetic syndrome	858,755	3,823	0.45%	3.95%
309.40-Adjustment disorder with mixed disturbance of emotions and conduct	858,755	3,283	0.38%	3.40%

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Diagnosis	N_Members	N_Members Served	% of N_Members	% of Top 10 Diagnoses
<b>8/1/2014 - 7/31/2015 Outpatient Medicaid 22+ Age Group</b>				
295.70-SCHIZOAFFECTIVE	359,194	5,094	1.42%	13.24%
311.00-Depressive disorder, not elsewhere classified	359,194	4,854	1.35%	12.61%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	359,194	4,553	1.27%	11.83%
296.32-Major depressive affective disorder, recurrent episode, moderate	359,194	4,231	1.18%	10.99%
295.30-PARANOID SCHIZOPHRENIA	359,194	3,876	1.08%	10.07%
296.80-Bipolar disorder, unspecified	359,194	3,845	1.07%	9.99%
300.00-ANXIETY STATE	359,194	3,524	0.98%	9.16%
296.30-Major depressive affective disorder, recurrent episode, unspecified	359,194	3,054	0.85%	7.94%
296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	359,194	2,883	0.80%	7.49%
295.90-SCHIZOPHRENIA NOS	359,194	2,571	0.72%	6.68%
<b>8/1/2014 - 7/31/2015 Outpatient Non-Medicaid 0 - 21 Age Group</b>				
314.01-Attention deficit disorder with hyperactivity	42,680	261	0.61%	28.56%
311.00-Depressive disorder, not elsewhere classified	42,680	110	0.26%	12.04%
304.30-CANNABIS DEPENDENCE	42,680	100	0.23%	10.94%
799.90-Other unknown and unspecified cause of morbidity and mortality	42,680	97	0.23%	10.61%
296.90-AFFECTIVE PSYCHOSIS	42,680	70	0.16%	7.66%
313.81-Oppositional defiant disorder	42,680	68	0.16%	7.44%
305.20-CANNABIS ABUSE	42,680	65	0.15%	7.11%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	42,680	56	0.13%	6.13%
296.32-Major depressive affective disorder, recurrent episode, moderate	42,680	44	0.10%	4.81%
304.00-DRUG DEPENDENCE	42,680	43	0.10%	4.70%
<b>8/1/2014 - 7/31/2015 Outpatient Non-Medicaid 22+ Age Group</b>				
303.90-OTHER & UNSPECIFIED ALCOHOL DEPENDENCE	300,956	1,281	0.43%	13.99%
296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	300,956	1,240	0.41%	13.54%
304.00-DRUG DEPENDENCE	300,956	1,163	0.39%	12.70%
296.32-Major depressive affective disorder, recurrent episode, moderate	300,956	968	0.32%	10.57%
296.80-Bipolar disorder, unspecified	300,956	830	0.28%	9.06%
296.30-Major depressive affective disorder, recurrent episode, unspecified	300,956	809	0.27%	8.83%
799.90-Other unknown and unspecified cause of morbidity and mortality	300,956	761	0.25%	8.31%
295.70-SCHIZOAFFECTIVE	300,956	722	0.24%	7.88%
311.00-Depressive disorder, not elsewhere classified	300,956	705	0.23%	7.70%
296.90-AFFECTIVE PSYCHOSIS	300,956	679	0.23%	7.41%

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**Race and Ethnicity**

Racial and ethnic diversity within the Louisiana Unit member population is another important consideration in an effective managed care initiative. There were little changes in the race and ethnicity percentages between 2014 and 2015 for both race and ethnicity. The Black/African American race showed the highest percentage in both eligibility (50.60%) and members served (51.83%), with the white/Caucasian race showing the second highest percentage in eligibility (37.77%) and members served (41.72%). Ethnicity data indicated that the Non-Hispanic/Non-Latino population represented the highest percentage for eligibility (96.26%) and members served (98.57%). Comparison of eligibility and members served populations showed consistent representation for both race and ethnicity. As seen in the previous contract year, Magellan received no member grievances between August 1, 2014 – July 31, 2015 related to ethnic/cultural or linguistic issues as perceived and reported by the member.

**Race**

		8/1/2013 - 7/31/2014				8/1/2014 - 7/31/2015			
Medicaid Status	Race	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Medicaid	American Indian/Alaskan Native	4,884	0.41%	588	0.46%	5,103	0.42%	623	0.45%
Medicaid	Asian	13,203	1.11%	360	0.28%	13,454	1.10%	395	0.29%
Medicaid	Black/African-American	611,145	51.16%	63,825	50.20%	616,284	50.60%	71,559	51.83%
Medicaid	Multi-Racial	7,381	0.62%	646	0.51%	8,376	0.69%	781	0.57%
Medicaid	Native Hawaiian/Pac Islander	1,152	0.10%	55	0.04%	1,376	0.11%	76	0.06%
Medicaid	Other/Single Race	36	0.00%	4	0.00%	51	0.00%	40	0.03%
Medicaid	White/Caucasian	455,140	38.10%	55,406	43.57%	460,048	37.77%	57,593	41.72%
Medicaid	Unknown	102,304	8.56%	6,649	5.23%	113,744	9.34%	7,291	5.28%
Medicaid	Total	1,194,519	100.00%	127,154	100.00%	1,217,949	100.00%	138,052	100.00%
Non-Medicaid	American Indian/Alaskan Native	828	0.29%	107	0.28%	1,125	0.33%	111	0.40%
Non-Medicaid	Asian	3,844	1.34%	72	0.19%	3,895	1.13%	55	0.20%
Non-Medicaid	Black/African-American	111,652	38.98%	7,529	19.46%	136,117	39.61%	5,698	20.30%
Non-Medicaid	Multi-Racial	1,334	0.47%	154	0.40%	2,069	0.60%	182	0.65%
Non-Medicaid	Native Hawaiian/Pac Islander	227	0.08%	15	0.04%	255	0.07%	14	0.05%
Non-Medicaid	Other/Single Race	6	0.00%	0	0.00%	11	0.00%	9	0.03%

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		8/1/2013 - 7/31/2014				8/1/2014 - 7/31/2015			
Medicaid Status	Race	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Non-Medicaid	White/Caucasian	84,906	29.64%	11,440	29.57%	105,879	30.81%	9,802	34.92%
Non-Medicaid	Unknown	83,758	29.24%	19,418	50.18%	94,415	27.48%	12,229	43.57%
Non-Medicaid	Total	286,421	100.00%	38,693	100.00%	343,636	100.00%	28,068	100.00%
Unknown	American Indian/Alaskan Native	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	Asian	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	Black/African-American	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	Multi-Racial	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	Native Hawaiian/Pac Islander	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	Other/Single Race	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	White/Caucasian	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	Unknown	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Unknown	Total	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Total	Total	1,454,407		167,380		1,521,616		168,254	

**Ethnicity**

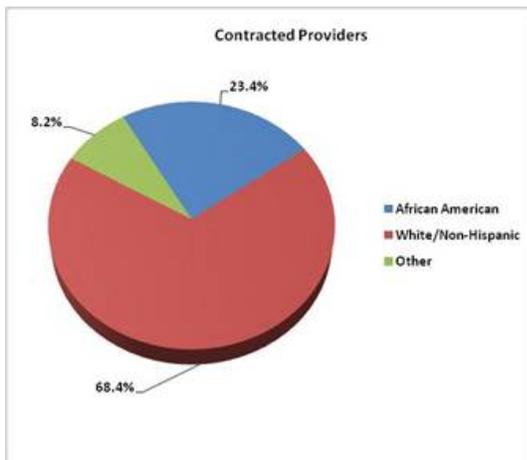
		8/1/2013 - 7/31/2014				8/1/2014 - 7/31/2015			
Medicaid Status	Ethnicity	N_Members	Percent	N_Members Served	Percent	N_Members	Percent	N_Members Served	Percent
Medicaid	HISPANIC OR LATINO	38,910	3.26%	1,547	1.22%	45,378	3.73%	1,967	1.42%
Medicaid	NON-HISPANIC OR NON-LATINO	1,155,581	96.74%	125,614	98.79%	1,172,373	96.26%	136,085	98.58%
Medicaid	Unknown	50	0.00%	1	0.00%	202	0.02%	3	0.00%
Medicaid	Total	1,194,519	100.00%	127,154	100.00%	1,217,949	100.00%	138,052	100.00%
Non-Medicaid	HISPANIC OR LATINO	9,214	3.22%	301	0.78%	6,757	1.97%	253	0.90%
Non-Medicaid	NON-HISPANIC OR NON-LATINO	223,102	77.89%	22,200	57.37%	273,667	79.64%	18,016	64.19%
Non-Medicaid	Unknown	54,138	18.90%	16,192	41.85%	63,230	18.40%	9,800	34.92%
Non-Medicaid	Total	286,421	100.00%	38,693	100.00%	343,636	100.00%	28,068	100.00%
Unknown	Unknown	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Unknown	Total	5,477	100.00%	5,477	100.00%	4,396	100.00%	4,396	100.00%
Total	Total	1,454,407		167,380		1,521,616		168,254	

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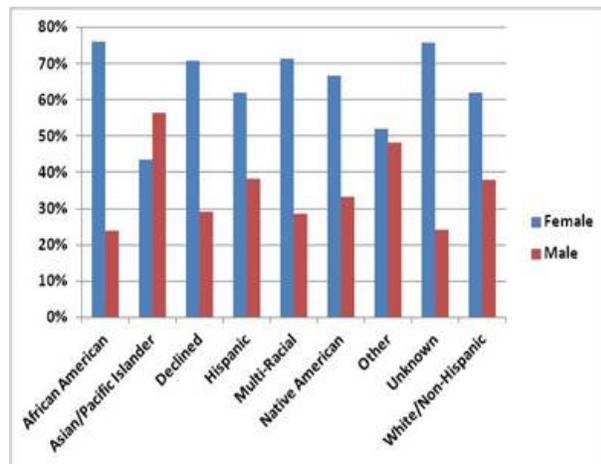
**B. Provider Network Demographics**

The demographic composition of the Louisiana Unit provider network is another important consideration in an effective managed care initiative. Standards have been established to promote the availability of behavioral health care practitioners and providers based on the assessed needs and preferences of its member population. It is important there be sufficient numbers and types of behavioral health care practitioners and providers conveniently located to serve the assessed needs and preferences of the covered population. In other words, the mix of practitioners and providers should be logically related to the known demographic characteristics of the covered population. A comparable ratio of staff to diversity in the community can positively impact members. It not only broadens the provider’s understanding of the community they work, it also helps bridge possible mistrust or historical trauma experienced by diverse populations. The following are graphical representations of contracted individual practitioners by race and gender (includes self reported data provided by practitioners) as of February 28, 2015.

**Individual Practitioners by Race**



**Individual Practitioners by Race & Gender**



Member demographics indicated that in 2015 African Americans comprise over half of the members served; however, only 23.4% of individual practitioners are African American as of September 30, 2015. Although there are differences in the practitioner and member mix, Magellan implements a robust cultural competency program to educate providers and ensure services are delivered in a culturally competent manner. Cultural competency training is included as part of provider orientation and ongoing training is provided by the Louisiana Unit to its staff and providers. Magellan also makes a Cultural Diversity Toolkit available to support both staff and providers in working with members. Full details on Magellan’s Cultural Competency Program are discussed later in this section.

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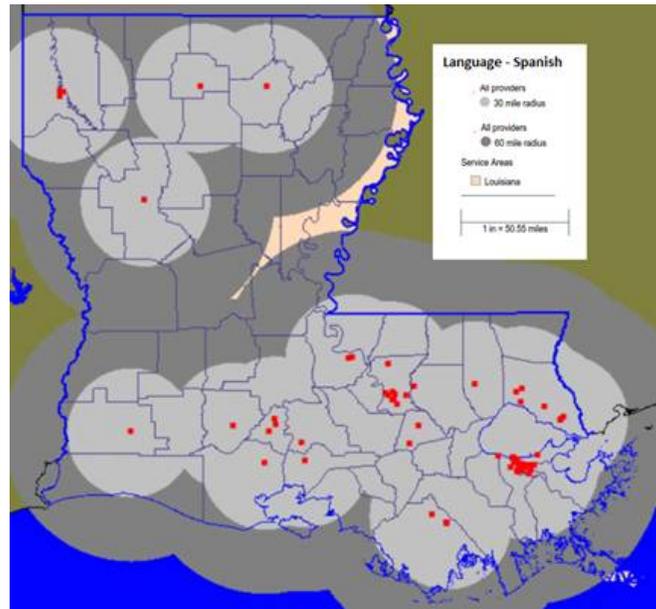
**Language Needs**

The Louisiana population served by the Louisiana Unit represents a diverse culture and Magellan has implemented services to address the language needs of minority members served, including access to translation services for members who require translations. Magellan ensures that members have access to translation or interpretative services at no cost to the member. Magellan contracts with Global Interpreting Network for translation services. Magellan also monitors its practitioner network and tracks the languages spoken in order to meet identified member needs whenever possible. Members whose preferred language is not English may have a difficult time describing their challenges with practitioners. It is essential to have staff that can accommodate the members’ needs. Magellan providers offer 20 language services other than English. There are 262 distinct practitioners at 394 service points who offer language proficiencies other than English, with Spanish having the highest representation. The below chart shows the distinct number of practitioners and service points for the languages offered.

<b>Language</b>	<b>Count</b>	<b>Service Points</b>
SPANISH	79	124
HINDI	44	68
FRENCH	25	30
ARABIC	23	29
URDU	21	34
TAGALOG	16	26
PUNJABI	13	13
SIGN LANGUAGE	11	17
TELUGU	6	12
GUJARATI	4	2
BURMESE	3	12
AFRIKAANS	2	1
CHINESE	2	2
CREOLE (Haitian)	2	3
MANDARIN	2	2
PORTUGUESE	2	13
RUSSIAN	2	2
SWEDISH	2	1
DUTCH	1	1
GERMAN	1	1
GREEK	1	1

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

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

### **C. Cultural Competency Program**

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

Guiding Principles for the Magellan Cultural Competency Program include:

- Acknowledging and respecting variance in behaviors, beliefs and values that influence mental health and incorporating those variables into assessment and treatment.
- Emphasizing member-centered care in the treatment and discharge processes.
- Incorporating natural supports such as family involvement and traditional healing practices when appropriate.

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- Encouraging active participation of the member and family in treatment. Incorporating adequate opportunities for feedback from members regarding policies and procedures.
- Developing an adequate provider network so that services are geographically, psychologically, and culturally accessible to consumers and families.
- Developing a comprehensive program to promote cultural sensitivity and competence.
- Promoting the integration of primary care, mental health care, and substance use services.

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

- Member grievances and provider complaints, including monitoring of grievances for issues that are potentially related to culturally insensitive practices.
  - There were no grievances related to cultural issues in contract year four.
  - There have not been any grievances reported related to cultural issues since implementation of the contract in 2012.
- Network access and availability measures including availability of individual practitioners, organizational providers, and providers who share the members' ethnic or language preference that are within a reasonable distance and timeframe (see **Provider Network Demographics** in this section).
- Treatment Record Review monitoring.
  - Magellan also monitors providers to ensure services are delivered in a culturally competent manner. Magellan includes two elements in the audit tools that are utilized to monitor for documentation for quality standards. Records were reviewed at 61 providers during contract year four March 1, 2015 – November 30, 2015. The below elements are evaluated by licensed clinicians during record reviews across all levels of care.

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

Treatment Record Review Element	Records in Compliance	Total Records Reviewed	Compliance Rate
8E Evidence of treatment being provided in a culturally competent manner.	595	608	97.86%
1B Cultural, language, religious, racial, ethnic, and sexual issues were assessed.	588.5	601	97.92%

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

Question		% Positive			
		CY1	CY2	CY3	CY4
Q17	Staff members were sensitive to my cultural background (race, religion, language, customs, etc)	84.8%	87.4%	85.1%	84.9%
Q18	My cultural preferences and race/ethnic background were included in planning services I received.	72.1%	72.4%	74.2%	72.6%

- Magellan establishes a minimum threshold of 80% when analyzing satisfaction survey data. Although there have been steady improvements in this measure since CY1, element Q18 (My cultural preferences and race/ethnic background were included in planning services I received) was identified as an opportunity for improvement. Further analysis indicated that there was 92.5% satisfaction for this element when evaluating positive and neutral responses, indicating many people may be impartial but not necessarily dissatisfied. There was also a large number of members (n=107) citing this element was not applicable to them. Magellan implemented interventions in contract year four including sharing results with practitioners and stakeholders to increase awareness of member perception of cultural sensitivity and implementing trainings to promote patient centered treatment planning that includes assessing for and addressing cultural background during treatment.

**III. Accessibility and Availability of Services**

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

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

**A. Telephonic Accessibility**

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

The following table presents the call volume, ASA (Average Speed Answer), and abandonment rates from March 1, 2015 to November 30, 2015. The goal for abandoned calls is 3% or fewer, and the goal for ASA is 30 seconds or less. Over the year, 124,384 calls were answered with a 20-second ASA and a 2.43% abandonment rate, meeting contractual performance guarantee goals for telephonic responsiveness.

Telephone responsiveness	Contract YTD
Numerator (number of abandoned inbound calls)	3,020
Denominator (Total number of inbound calls)	124,384
Call Abandonment Rate - Member/ Provider Services Line(s) 3% percent or less	2.43%
Numerator (Total average seconds to answer)	2,394,525
Denominator (Total calls answered)	119,129
Average Speed to Answer (ASA) in seconds– Member/Provider Services Line(s) all calls (pooled) answered within an average of 30 seconds	20.10

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Telephone responsiveness	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4
Call Abandonment Rate (Goal: 3%)	1.39%	2.57%	2.70%	2.43%
Average Speed to Answer (ASA) in seconds (Goal: 30 seconds)	7.4	16.58	19.12	20.10

**B. Appointment Access**

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

**C. Geo-Access & Density Accessibility**

Magellan has an established LBHP behavioral health provider network consisting of licensed mental health professionals, hospitals, youth residential facilities, residential substance use facilities, substance use IOP and OP providers, evidence-based practice service providers and home and community-based service providers for adults and children. Magellan implements processes and procedures that address network development and recruitment. Our goal is not only to maintain a comprehensive network that is consistent in size and variety to meet the needs of Louisiana Medicaid managed care members, but to identify opportunities to invest in the delivery system resulting in improved service access and improved member outcomes. The Network Strategy Committee (NSC) oversees the Network Development Plan and reports to the Quality Improvement Committee (QIC). The NSC is established to ensure the quality management program reviews and analyzes program data to accessibility indicators, including in network geographic access and appointment availability data, the results of member satisfaction surveys, and member/family complaints to identify gaps in the type, density, and location of behavioral health providers in Magellan’s network.

Geographic access standards are established to ensure that contracted practitioners and facilities are available in the communities in which members reside. Magellan evaluates provider types using a standard of a 30-mile radius for members living in urban or suburban areas and 60 miles for those living in rural areas. The chart below outlines the geo-access rates as of September 30, 2015.

Member Group	Access Standard: One Provider in	Average Distance to Provider (miles)	Members with Desired Access	Members without Desired Access	Total Members	Compliance Rate (%)
Inpatient Hospital: Urban/Suburban	- 30 miles	2.6	483,262	-	483,262	100.0%
Inpatient Hospital: Rural	- 60 miles	12.7	906,661	1,151	907,812	99.9%
OBH Clinics: Urban/Suburban	- 30 miles	3.6	483,262	-	483,262	100.0%

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<b>Member Group</b>	<b>Access Standard: One Provider in</b>	<b>Average Distance to Provider (miles)</b>	<b>Members with Desired Access</b>	<b>Members without Desired Access</b>	<b>Total Members</b>	<b>Compliance Rate (%)</b>
OBH Clinics: Rural	- 60 miles	10.6	907,143	669	907,812	99.9%
PRTF: Urban/Suburban	- 30 miles	41.7	165,695	317,567	483,262	34.3%
PRTF: Rural	- 60 miles	48.0	603,149	304,663	907,812	66.4%
Non-Medical Group Home: Urban/Suburban	- 30 miles	17.6	381,561	101,701	483,262	79.0%
Non-Medical Group Home: Rural	- 60 miles	36.9	718,412	189,400	907,812	79.1%
TFC: Urban/Suburban	- 30 miles	8.0	457,515	25,747	483,262	94.7%
TFC: Rural	- 60 miles	28.5	832,715	75,097	907,812	91.7%
TGH: Urban/Suburban	- 30 miles	32.1	167,987	315,275	483,262	34.8%
TGH: Rural	- 60 miles	49.1	579,817	327,995	907,812	63.9%
Crisis Adult Residential: Urban/Suburban	- 30 miles	72.1	257,041	226,221	483,262	53.2%
Crisis Adult Residential: Rural	- 60 miles	133.7	232,150	675,662	907,812	25.6%
<b>ASAM</b>						
ASAM Level I: Urban/Suburban	- 30 miles	1.0	483,262	-	483,262	100.0%
ASAM Level I: Rural	- 60 miles	5.8	907,812	-	907,812	100.0%
ASAM Level II.1: Urban/Suburban	- 30 miles	2.4	483,262	-	483,262	100.0%
ASAM Level II.1: Rural	- 60 miles	10.3	907,240	572	907,812	99.9%
ASAM Level III.1: Urban/Suburban	- 30 miles	5.7	473,088	10,174	483,262	97.9%
ASAM Level III.1: Rural	- 60 miles	23.9	877,978	29,834	907,812	96.7%
ASAM Level III.2D: Urban/Suburban	- 30 miles	37.2	384,682	98,580	483,262	79.6%
ASAM Level III.2D: Rural	- 60 miles	72.0	523,770	384,042	907,812	57.7%
ASAM Level III.3 & 5: Urban/Suburban	- 30 miles	4.2	482,297	965	483,262	99.8%
ASAM Level III.3 & 5: Rural	- 60 miles	23.0	896,683	11,129	907,812	98.8%
ASAM Level III.7: Urban/Suburban	- 30 miles	28.6	359,630	123,632	483,262	74.4%
ASAM Level III.7: Rural	- 60 miles	54.4	571,018	336,794	907,812	62.9%
ASAM Level III.7D: Urban/Suburban	- 30 miles	7.8	473,088	10,174	483,262	97.9%
ASAM Level III.7D: Rural	- 60 miles	26.9	869,855	37,957	907,812	95.8%
ASAM Level IV: Urban/Suburban	- 30 miles	7.7	459,790	23,472	483,262	95.1%
ASAM Level IV: Rural	- 60 miles	28.1	856,365	51,447	907,812	94.3%
<b>CSOC</b>						
CSOC Crisis Stabilization: Urban/Suburban	- 30 miles	-	-	483,262	483,262	0.0%
CSOC Crisis Stabilization: Rural	- 60 miles	127.2	175,996	731,816	907,812	19.4%
CSOC Independent	- 30 miles	2.1	483,262	-	483,262	100.0%

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Member Group	Access Standard: One Provider in	Average Distance to Provider (miles)	Members with Desired Access	Members without Desired Access	Total Members	Compliance Rate (%)
Living/Skills Building: Urban/Suburban						
CSOC Independent Living/Skills Building: Rural	- 60 miles	11.5	907,312	500	907,812	99.9%
CSOC Parent Support & Training: Urban/Suburban*	- 30 miles	* One statewide provider who will travel to service location.				100.0%
CSOC Parent Support & Training: Rural*	- 60 miles	* One statewide provider who will travel to service location.				100.0%
CSOC Short Term Respite Care: Urban/Suburban	- 30 miles	13.2	418,297	64,965	483,262	86.6%
CSOC Short Term Respite Care: Rural	- 60 miles	29.0	816,697	91,115	907,812	90.0%
CSOC Youth Support & Training: Urban/Suburban*	- 30 miles	* One statewide provider who will travel to service location.				100.0%
CSOC Youth Support & Training: Rural*	- 60 miles	* One statewide provider who will travel to service location.				100.0%
* One statewide provider who will travel to service location.						
<b>PROGRAMS</b>						
ACT: Urban/Suburban	- 30 miles	4.7	482,297	965	483,262	99.8%
ACT: Rural	- 60 miles	27.6	875,088	32,724	907,812	96.4%
Case Conference: Urban/Suburban	- 30 miles	1.9	483,262	-	483,262	100.0%
Case Conference: Rural	- 60 miles	9.2	907,312	500	907,812	99.9%
CPST: Urban/Suburban	- 30 miles	1.4	483,262	-	483,262	100.0%
CPST: Rural	- 60 miles	7.0	907,312	500	907,812	99.9%
Crisis Intervention: Urban/Suburban	- 30 miles	1.4	483,262	-	483,262	100.0%
Crisis Intervention: Rural	- 60 miles	7.1	907,312	500	907,812	99.9%
FFT: Urban/Suburban	- 30 miles	7.2	461,242	22,020	483,262	95.4%
FFT: Rural	- 60 miles	27.6	819,546	88,266	907,812	90.3%
Homebuilders: Urban/Suburban	- 30 miles	5.8	473,073	10,189	483,262	97.9%
Homebuilders: Rural	- 60 miles	22.1	893,138	14,674	907,812	98.4%
Multi-Systemic Therapy: Urban/Suburban	- 30 miles	4.3	473,339	9,923	483,262	97.9%
Multi-Systemic Therapy: Rural	- 60 miles	18.8	901,797	6,015	907,812	99.3%
PSR: Urban/Suburban	- 30 miles	1.4	483,262	-	483,262	100.0%
PSR: Rural	- 60 miles	7.5	907,312	500	907,812	99.9%

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Member Group	Access Standard: One Provider in	Average Distance to Provider (miles)	Members with Desired Access	Members without Desired Access	Total Members	Compliance Rate (%)
<b>PRACTITIONERS</b>						
<b>All Practitioners: Urban/Suburban</b>	- 30 miles	0.8	483,262	-	483,262	100.0%
<b>All Practitioners: Rural</b>	- 60 miles	4.6	907,812	-	907,812	100.0%
<b>PRACTITIONERS: PRESCRIBERS</b>						
<b>All Prescribers: Urban/Suburban</b>	- 30 miles	1.2	483,262	-	483,262	100.0%
<b>All Prescribers: Rural</b>	- 60 miles	6.1	907,312	500	907,812	99.9%
Psychiatrists: Urban/Suburban	- 30 miles	1.3	483,262		483,262	100.0%
Psychiatrists: Rural	- 60 miles	7.4	907,312	500	907,812	99.9%
Psychologists Rx: Urban/Suburban	- 30 miles	5.8	477,115	6,147	483,262	98.7%
Psychologists Rx: Rural	- 60 miles	22.4	800,423	107,389	907,812	88.2%
APRN Rx: Urban/Suburban	- 30 miles	3.6	483,262		483,262	100.0%
APRN Rx: Rural	- 60 miles	14.1	898,520	9,292	907,812	99.0%
<b>PRACTITIONERS: NON-PRESCRIBERS</b>						
<b>Non-Prescribers: Urban/Suburban</b>	- 30 miles	1.2	483,262	-	483,262	100.0%
<b>Non-Prescribers: Rural</b>	- 60 miles	6.3	907,312	500	907,812	99.9%
Psychologists: Urban/Suburban	- 30 miles	2.3	482,318	944	483,262	99.8%
Psychologists: Rural	- 60 miles	13.5	907,312	500	907,812	99.9%
LPC: Urban/Suburban	- 30 miles	1.2	483,262	-	483,262	100.0%
LPC: Rural	- 60 miles	6.8	907,260	552	907,812	99.9%
LCSW: Urban/Suburban	- 30 miles	1.2	483,262	-	483,262	100.0%
LCSW: Rural	- 60 miles	8.3	907,260	552	907,812	99.9%
Registered Nurse: Urban/Suburban	- 30 miles	2.4	483,262	-	483,262	100.0%
Registered Nurse: Rural	- 60 miles	9.5	907,312	500	907,812	99.9%
Other Masters Level Practitioners: Urban/Suburban	- 30 miles	1.5	483,262	-	483,262	100.0%
Other Masters Level Practitioners: Rural	- 60 miles	8.3	907,345	467	907,812	99.9%
Other Licensed Practitioners: Urban/Suburban	- 30 miles	2.4	483,262	-	483,262	100.0%
Other Licensed Practitioners: Rural	- 60 miles	9.5	907,312	500	907,812	99.9%
<b>INPATIENT</b>						
Inpatient ECT: Urban/Suburban	- 30 miles	80.1	97,469	385,793	483,262	20.2%
Inpatient ECT: Rural	- 60 miles	95.0	292,610	615,202	907,812	32.2%
Inpatient Psych Hospital: Urban/Suburban	- 30 miles	3.2	483,262	-	483,262	100.0%
Inpatient Psych Hospital: Rural	- 60 miles	12.8	906,661	1,151	907,812	99.9%
<b>OUTPATIENT</b>						

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Member Group	Access Standard: One Provider in	Average Distance to Provider (miles)	Members with Desired Access	Members without Desired Access	Total Members	Compliance Rate (%)
Outpatient ECT: Urban/Suburban	- 30 miles	80.1	97,469	385,793	483,262	20.2%
Outpatient ECT: Rural	- 60 miles	95.0	292,610	615,202	907,812	32.2%
Outpatient Psych: Urban/Suburban	- 30 miles	6.2	437,064	46,198	483,262	90.4%
Outpatient Psych: Rural	- 60 miles	21.5	858,710	49,102	907,812	94.6%
<b>OTHER</b>						
Laboratory Services: Urban/Suburban	- 30 miles	5.9	471,426	11,836	483,262	97.6%
Laboratory Services: Rural	- 60 miles	20.6	890,282	17,530	907,812	98.1%
Wrap-Around Services: Urban/Suburban	- 30 miles	10.2	470,303	12,959	483,262	97.3%
Wrap-Around Services: Rural	- 60 miles	24.7	885,290	22,522	907,812	97.5%

Throughout contract year four, Magellan actively worked with DHH-OBH as part of a comprehensive transition plan to prepare network providers for integration into the Bayou Health Plans. Crisis services as an integral part of the network. Although Adult Crisis Residential Level of Care (LOC) did not meet compliance rates, Crisis Intervention was a LOC available to 100% of adults in urban areas and 99.9% of adults in rural areas. As the CSoC Coordinator, Magellan will maintain and continue provider recruitment activities. Details of this will be available in the CSoC Network Development Plan submitted as part of the contract implementation plan.

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

The Magellan Health Services Louisiana Unit Quality/Clinical Work Plan for Louisiana Behavioral Health Partnership sets forth all the performance measures and activities for services managed by the Louisiana Unit. In addition, it outlines and describes the specific activities to be conducted during the year to promote the quality process throughout the organization and support the objectives of the Quality Program. The following performance measures show operational and quality outcomes for claims administration, telephone responsiveness, clinical, and member satisfaction. All goals were met for contract year four.

Performance Guarantees	2015 Goal	Met / Not-Met (Year to Date)	Actions to Address
<b>Claims administration</b>			
Financial payment (dollar) accuracy-97% of audited claim dollars paid accurately	97%	99.93%	Met
Procedural (statistical)Accuracy	98%	99.96%	Met
(TAT) – 95% of clean claims paid to all providers within 30 days	95%	99.98%	Met
TAT – 99% of all provider claims paid within 45	99%	99.99%	Met

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Performance Guarantees	2015 Goal	Met / Not-Met (Year to Date)	Actions to Address
days			
<b>Telephone responsiveness</b>			
Call Abandonment Rate - Member/ Provider Services Line(s) 5% percent or less for Year 1 and less than 3% for year 2	>3%	2.43%	Met
Average Speed to Answer (ASA) – Member/Provider Services Line(s) all calls (pooled) answered within an average of 30 seconds	30 seconds	20.10	Met
<b>Clinical</b>			
Ambulatory follow up within 7 days of discharge from 24-hour facility	28%	30.87%	Met (YTD Calendar Quarters; Q1 and Q2 only)
Ambulatory follow up within 30 days of discharge from 24-hour facility	48%	49.82%	Met (YTD Calendar Quarters; Q1 and Q2 only)
Readmission Rate – 15% or less of Members readmitted within 30 days to same acute level of care for Year 1; less than 12 percent of Members readmitted within 30 days to same acute level of care in Year 2	<12%	9.74%	Met (Contact Quarters; Q1 and Q2)
Percent of adult high service users (two or more IP admissions or four ER visits in a year) enrolled in an assertive community treatment program or psychosocial rehab.	15%	27.27%	Met (One Year Look Back; Sept 2014-Aug 2015)
<b>Satisfaction Surveys</b>			
Annual Member Satisfaction Survey:	83%	87.5%	Met
Annual Provider Satisfaction Survey:	87.7%	N/A	Provider Survey was not a contract requirement for CY4

**V. Quality Improvement Activities and Performance Improvement Projects**

The QI department monitors critical performance measures on an ongoing basis to determine if opportunities for improvement are identified. The Louisiana Unit also works with contract monitors to determine if statewide improvements are needed. The Louisiana Unit continued four established Performance Improvement Projects (PIP’s) in contract year four. All Projects used the Six Sigma DMAIC framework by identifying metrics and barriers and implementing solutions. Statistical analysis using the Six Sigma analyzes the number of defects in a process compared to baseline results to show statistical improvement. The sigma levels range from 0 to 6 with any increase showing statistical improvement. The four formal PIPs for contract year four were: Improve Member Access to Emergent, Urgent, and

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Routine Appointments; Improve the Number of CSoc Treatment Plans (Plans of Care) with Service Authorization at First Review; Transitional Care, and Improving Adverse Incident Reporting. Information will be presented using the standardized IPRO format. Each project will include details on the project topic, methodology, interventions, results and conclusions. All projects were closed in September 2015 due to contract termination.

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

**Project Topic**

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**Project Topic**

As part of the implementation of managed care, the Louisiana Behavioral Health Partnership identified access to care as a priority for formal performance monitoring and improvement as part of the contract requirements for contract years one through four.

**Rationale for Topic Selection**

It is important for members to be able to access care within appropriate timeframes once a need is recognized and based on the urgency of the issue. Avoiding delays in care is essential to prevent further deterioration of the member's condition. One of Magellan's primary functions is to ensure that members are able to promptly access behavioral healthcare services based on the presenting issue. Timely access to care impacts satisfaction and potentially clinical outcomes; therefore, it is important for the Louisiana Unit to monitor the promptness with which members are able to access emergent, urgent, and routine services.

**Aim Statement**

The aim of the Improve Member Access to Emergent, Urgent, and Routine Appointments Performance Improvement Plan (Appointment Access PIP) is to ensure members receive access to services based on their needs and to improve member access to emergent, urgent, and routine appointments when deficiencies are identified. This is done by monitoring appointment access indicators, including grievance and satisfaction survey data, and implementing interventions when opportunities for improvement are identified.

**Methodology**

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**Performance Indicators**

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

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

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

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

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

This indicator assesses the percentage of members who access service within the required timeframe. Timeframes for emergent access are within one hour of request, urgent access within 48 hours/2 calendar days and routine access within 14 calendar days. Classification of appointment urgency is authorization based and reports are pulled from Magellan's Integrated Product (IP) database. Services access is claims based metric. Access is evaluated against corporate access goals of 95% for emergent and urgent appointment access and 70% for routine access.

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

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

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

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

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

- Staff was willing to see my child as often as I felt was necessary.
- Staff returned our call(s) in 24 hours.
- Services were available at times that were good for us.
- The time my child waited between appointments was acceptable.

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- My family got as much help as we needed for my child.
- My child was able to see a psychiatrist when he/she wanted to.

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

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

This indicator assesses members' dissatisfaction with access to care.

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

**Procedures**

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

*Emergent – An individual in need of an emergent appointment is at serious or extreme risk of harm, such as current suicidal ideation with expressed intentions, recent use of substances resulting in decreased inhibition of harmful behaviors, repeated episodes of violence toward self or others, or extreme compromise of ability to care for oneself leading to physical injury.*

*Urgent – An individual in need of an urgent appointment is at moderate risk of harm, such as suicidal ideation without intent or binge use of substances resulting in potentially harmful behaviors without current evidence of such behavior.*

*Routine – An individual in need of a routine appointment is at minimal to low risk of harm, such as absence of current suicidal ideation or substance use without significant episodes of potentially harmful behavior.*

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As defined, emergent and urgent appointments are driven by the request of the member or a provider on behalf of a member. The access to service process and standards are applicable for members who are not in a healthcare setting at the time of contact with Magellan. Emergent and urgent requests are handled telephonically. When members or providers on behalf of members contact Magellan by telephone, they are assessed for the level of clinical urgency (i.e., emergent, urgent or routine, including members that selected the crisis option on the call-in menu). A member identified as experiencing a life-threatening emergent level of clinical urgency is assisted by the Magellan care management staff with securing transport to an emergency room and a 9-1-1 call out as necessary. When a member is not currently in service with a behavioral health provider and is assessed at an urgent level of clinical urgency, the Magellan care management staff assists the member in securing an appointment with a network provider within the required timeframe (i.e., 48 hours). Members currently being treated by a behavioral health provider and assessed as non-life threatening or urgent level of clinical urgency are referred to their treating provider for direction. It is important to note that contact with Magellan is often not necessary for provider to address urgent needs. Member benefits include pass-through therapy services, which can be utilized to address urgent needs if necessary. Pass-through services do not require authorizations and can be provided without contact with Magellan.

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

- B. Indicator 2:** Data collected from Magellan utilization management system (IP) and claims system (CAPS) fields for Date of Request to Date of Claim for first service after request. See Indicator one for details on classification of appointment. This measure uses six sigma methodologies. Six Sigma methodology is a measurement-based approach that focuses on process improvement and variation reduction. Six Sigma describes quantitative, statistical representation of how a process is performing. To achieve Six Sigma, a process must not produce more than 3.4 defects per million opportunities. A Six Sigma defect is defined as

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anything outside of customer specifications, in this case members who do not receive a service within established timeframes. Each indicator includes a sigma level from zero to six, with six showing the highest level of compliance. Increases in sigma level are considered improvements.

- C. Indicator Three:** The Louisiana Unit utilizes the Magellan Member Experience of Care survey to collect data on satisfaction. The survey, based on the Mental Health Statistics Improvement Program (MHSIP) Consumer survey, was modified for the public sector to promote consistency with surveys administered company-wide for the Medicaid population. Youth and adult versions are used to address the unique needs of each population subset. The survey responses are based on a balanced scale with a neutral middle for most questions.

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

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

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

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

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after the second mailing (02/9/2015, 02/10/2015). Results were calculated and analyzed by the Magellan national survey department to ensure statistical validity and reliability of the results.

**Indicator Four:** Magellan defines a grievance as any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which Magellan or a delegated entity provides health care services, regardless of whether any remedial action can be taken. A grievance may include a complaint about any of the following:

1. Access to care or service;
2. Quality, timeliness, and/or appropriateness of care or service;
3. Attitude and service orientation of practitioner/provider, practitioner/provider's staff, or Magellan staff;
4. Utilization management process;
5. Inaccurate or inadequate information;
6. Care or service rendered by practitioners/providers;
7. General dissatisfaction with a co-payment amount; or
8. A decision not to expedite an organization determination or reconsideration.

Magellan tracks grievances related to access to care or service in this PIP. When a caller contacts Magellan with a grievance, we walk them through the grievance process, and if a referral is required, we provide the appropriate contact information and, where possible, warm transfer the individual to the correct entity for follow up. All grievances are documented into Magellan's web-based Complaint and Resolution Tracking (CART) system for quality management purposes. Magellan resolves each grievance individually; however, data generated by the grievance management system is also used to identify and address any trends or patterns in use or misuse of services, such as a disproportionate number of an individual type of grievance or a high or increasing number of grievances related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the appropriate committee conducts a root cause analysis and recommends interventions.

### **Project Timeline**

Data is monitored quarterly. Baseline data was collected in the first contract year (3/1/12-2/28/13). Re-measurement data was collected for the second contract year (3/1/13-3/28/14), third contract year (3/1/14-2/28/15), and fourth contract year (3/1/15-8/31/15).

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Event	Timeframe
Baseline Measurement Period	3/1/2012 through 2/28/2013
Interim Measurement Period	Quarterly 3/1/2013 through 8/31/2015
Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Quarterly 3/1/2013 through 8/31/2015
Intervention Implementation	See Interventions below
Analysis of Project Data	Quarterly 3/1/2013 through 8/31/2015
Submission of Final Report	10/15/2015

**Interventions/Changes for Improvement**

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**Barrier Analyses**

Barriers affecting appointment access include:

**A. Member Barriers**

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

**B. Provider Barriers**

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

**C. Magellan Barriers**

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

**Interventions Planned and Implemented**

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Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
Grievance Interventions	Monitor member grievances or provider complaints as they are received. Each grievance/complaint is acknowledged and addressed individually. Magellan tracks and trends to identify if multiple grievances are submitted for a provider or region. Magellan’s network department reviews data to determine if network development is needed to improve access for an area/region/service type or if a specific provider requires a corrective action plan to ensure compliance with access standards.	A	QI and Network	March 2012 and ongoing	Established; Will continue through November 2015
	Internal training of Magellan staff on identifying member dissatisfaction (grievances), including those related to access, and reporting grievances in the CART tracking system. Once grievances increase to a level deemed appropriate to the CMC, an initiative will be formed to decrease the level of grievances.	A	Grievance Coordinator	July 2013	Established; Will continue through November 2015
	Contact providers and discuss appointment access standards when member grievance regarding access to care is received.	A	Grievance Coordinator/Network	7/2013 and ongoing	Established; Will continue through November 2015
Provider Access Interventions	Educate providers through network contacts, provider focus groups, and member service contacts to ensure the providers understand and are able to meet the contractual expectations for appointment standards.	B	Network/Member Service/Clinical Staff	6/2013 and ongoing	Completed in March 2015
	E-mail blast reminding all providers of the contractual obligation to access standards and educating them on keeping their practice information updated via the provider website.	B	Network Administrator	11/2013	Completed
	Implement a quarterly survey of a sample of providers to monitor availability of emergent, urgent, & routine appointments. This survey will be administered by the Member Service Representatives who will call on behalf of Magellan using a planned script to inquire regarding availability of appointments related to access type. If survey finds provider does not meet established access standards, a follow-up letter is sent to provider discussing expectations and requesting planned actions to comply with appointment access standards.	B	Member Service Supervisor/QI Manager	6/2013 and ongoing	Completed in August 2015

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Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	Network conducted a survey to providers (non-inpatient) requesting information about their specialties and availability; the network department updated provider records and provider search to ensure accurate provider availability is documented.	B	Network Administrator	12/2013	Completed in August 2015
Member Access Interventions	Member Services Representatives will assist members that contact Magellan seeking assistance in obtaining appointment; outpatient support specialists and/or care managers will assist member in secure appointment within established timeframes depending on need (e.g., emergent, urgent, routine).	A, C	Member Service Staff/Care Manager	6/2013 and ongoing	Established; Will continue through November 2015
	Educate members on access standards via member service calls; as part of discussion, reinforce with member that Magellan is available to assist and member should call back if unable to obtain timely appointment.	A,C	Member Service Staff/ Supervisor	6/2013 and ongoing	Established; Will continue through November 2015
TGH	Assist in the expansion of the youth residential system in partnership with Seaside Healthcare.	C	Network Administrator	10/2014-11/2015	Established; Will continue through November 2015
Ad Hoc Interventions	<p>Analysis network composition regularly through review of ad hoc reporting. In light of the transition of the integrated specialty behavioral health services into Medicaid managed care system, Magellan discontinued contracting and credentialing new providers as of May 31, 2015. However the following recruitment interventions will be implemented:</p> <ul style="list-style-type: none"> <li>* Recruitment efforts will be initiated in areas where frequent ad hocs are completed due to lack of network availability.</li> <li>* Any time our ad hoc agreements increase by more than 25% within Louisiana or there is a significant increased trend in ad hoc agreements over a 2 month time period, Magellan would initiate recruitment activities.</li> </ul>	C	Network Administrator	6/2015-ongoing	Established; Will continue through November 2015

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Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	* If there are multiple ad hocs agreements for a specific provider, Magellan will reach out to attempt to recruit the provider.				
Adding New Services	Magellan will work with credentialed providers to add new services to existing contracts as requested.	C	Network Administrator	6/2015-	Established; Completed August 2015
Systems Barrier Reporting	Developed standardized reporting process for agency partners, members, and providers to identify system barriers, including barriers related to access to care. Magellan reports issues to a monthly joint DCFS/OJJ/OBH meeting that reviews data and determines action steps.	C	Quality Management Administrator	11/2014 - ongoing	Established; Completed October 2015
Independent Assessment/ Community Based Care Management (IA/CBCM) for Adults	<p>Implemented a four phased rollout of a new Independent Assessment/ Community Based Care Management (IA/CBCM) Plan of Care procedure that replaced the old authorization process for members eligible for the 1915(i) State Plan Amendment. The 1915(i) State Plan Amendment provides expanded home and community based services as determined by clinical and financial eligibility (e.g., adult members with Severe and Persistent Mental Illness). The Independent Assessor/ Community-Based Care Manager serves as the independent conflict-free LMHP who will:</p> <ul style="list-style-type: none"> <li>• Assess member eligibility and needs;</li> <li>• Develop a plan of care (POC) that addresses needs identified in the assessment; and</li> <li>• Coordinate the overall delivery of home and community based services to the member.</li> </ul> <p>The new process brings Magellan into compliance with federal and state waiver performance measures that were validated by IPRO during this review. The POC is a service plan that will be used to inform the treating home and community based provider's treatment plan. As part of the process, IA/CBCM informs members what services are available to them and helps them navigate system to ensure needs are met. The IA/CBCM is available throughout the year if the member requires a change in POC.</p>	A, C	Adult Systems Administrator	June 2014- October 2014	Established; Will continue through November 2015

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Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	A random selection of high volume providers is chosen quarterly for review in the process outlined in the TRR intervention. A sample of 385 members is reviewed annually in an onsite provider review. Magellan monitors if members are receiving services as indicated on their POC. It also monitors to ensure POC are updated when warranted by member's need. Providers who do not meet 100% compliance with waiver performance measures are required to submit a CAP.	A, C	QI Manager	11/ 2013	Established; Completed September 2015
	Waiver Performance Measure data are reviewed quarterly by Magellan's Quality Improvement Committee (QIC) and the Department of Health and Hospital's Interdepartmental Monitoring Team to determine if systemic opportunities for improvement are identified. If so, Magellan, in collaboration with the IMT Committee, will utilize the DMAIC (Define Measure Analysis Improve Control) model to conduct barrier analysis and develop interventions. Data is reviewed quarterly to determine effectiveness of interventions and determine next steps.	A, C	QI Manager	August 2013	Established; Completed September 2015

**Results**

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

Date	Num	Denom	Emergent	Num	Denom	Urgent	Num	Denom	Routine
CY1	1,657	1,765	93.88%	15,727	16,009	98.24%	58,503	58,860	99.39%
CY2	1,524	1,694	89.96%	41,840	42,172	99.21%	64,967	65,264	99.54%
CY3	571	619	92.25%	20,457	20,981	97.50%	137,100	138,490	99.00%
CY4*	219	226	96.90%	10,545	10,572	99.74%	63,843	64,339	99.23%

\* Through Q2

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

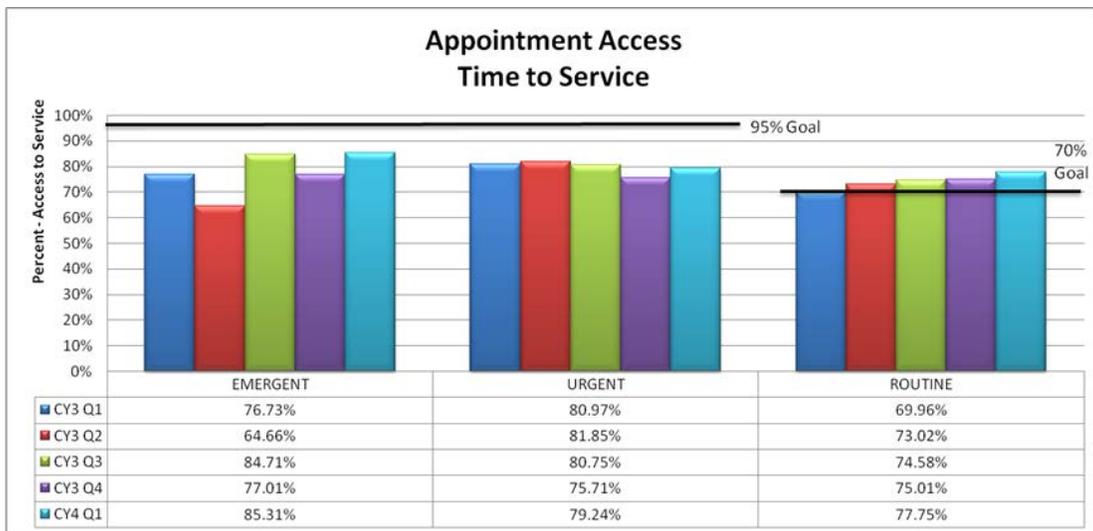
**Contract Year 3 and Year 4 Data by Quarters**

Quarters	CY3 Q2	CY3 Q3	CY3 Q4	CY4 Q1
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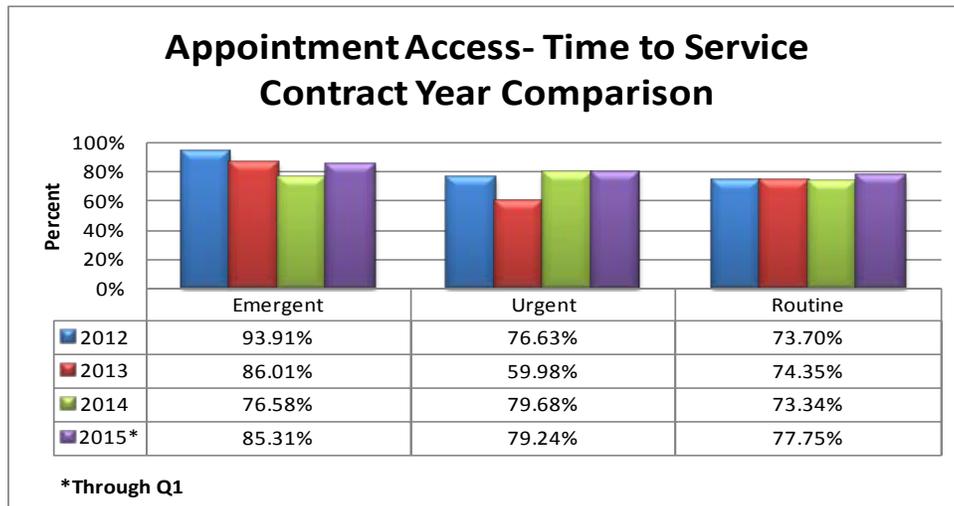
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Metrics	Volume	Percent	Sigma Level									
Emergent	116	64.66%	1.88	157	84.71%	2.52	187	77.01%	2.24	143	85.31%	2.55
Urgent	4827	81.85%	2.41	4950	80.75%	2.37	5734	75.71%	2.20	6434	79.24%	2.31
Routine	32935	73.02%	2.11	39297	74.58%	2.16	36740	75.01%	2.17	39180	77.75%	2.26

**Comparison of Contract Year 3 and Contract Year 4 by Contract Quarter**



**Comparison of Contract Year Data**



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

**Contract Year 1 through 4 Comparison of Member satisfaction with access to care – Minors**

Question	% POSITIVE			
	CY1	CY2	CY3	CY4
Staff was willing to see my child as often as I felt was necessary.	87.0%	89.1%	88.5%	80.5%
Staff returned our call(s) in 24 hours.	83.0%	86.3%	86.3%	83.3%
Services were available at times that were good for us.	84.0%	85.5%	86.3%	84.0%
The time my child waited between appointments was acceptable.	81.5%	84.4%	82.0%	81.0%
My family got as much help as we needed for my child.	81.1%	77.6%	82.2%	77.5%
My child was able to see a psychiatrist when he/she wanted to.	72.9%	75.6%	77.6%	71.8%

**Contract Year 1 through 4 Comparison of Member satisfaction with access to care – Adults**

Question	% POSITIVE			
	CY1	CY2	CY3	CY4
Staff was willing to see me as often as I felt it was necessary.	79.7%	82.6%	82.9%	86.5%
Staff returned my call(s) in 24 hours.	71.4%	80.9%	75.9%	81.8%
Services were available at times that were good for me.	83.5%	84.2%	80.8%	87.5%
The time I waited between appointments was acceptable.	79.7%	79.3%	78.6%	88.0%
I was able to get all the services I thought I needed.	79.4%	78.7%	79.2%	85.9%
I was able to see a psychiatrist when I wanted to.	76.1%	76.7%	71.5%	78.1%

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

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

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**Discussion**

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**Discussion of Results**

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

Indicator one metrics show high compliance rates for emergent, urgent and routine in the first two quarters of contract year four. This indicator measures Magellan’s authorization process for emergent, urgent and routine appointment requests. All three compliance rates met and exceeded their established goals specified in this document and the contract. The emergent compliance rate exceeded the 95% performance goal by 1.90 percentage points, the urgent compliance rate exceeded the 95% performance by 4.74% percentage points, and the routine compliance rate far exceeds the performance goal of 70% with a 99.23% compliance rate; in the first two quarters of contract year four. All three compliance rates increased in first two quarters of contract year four and the emergent compliance rate showed the largest increase over the previous year of 4.65 percentage points.

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

Indicator two measures if there is a claim for a service within the appointment access standards from the date of the request. Each of these metrics are dependent on the member going to the scheduled appointment that was authorized by Magellan as referenced in indicator one. Routine appointment access has consistently met the established goal of 70% and showed increasing sigma levels, indicating a statistical representation of improvement. Routine appointment access was 7.75 percentage points above the established goal of 70% in the first quarter of contract year four and exceeded the established goal over the past four years. Emergent metrics showed an upward trend for the past four quarters while urgent metric slightly decreased over the past four quarters. Emergent appointment access was 9.69 percentage points below the established goal of 95% in the first quarter of contract year four; however, there was an 8.73 percentage point increase over the contract year three rate. Urgent appointment access remained below the goal of 95% by 15.76 percentage points in the first quarter of contract year four and remained consistent with the contract year 3 rate.

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

Three of the five satisfaction survey elements on the minor survey exceeded the 80% threshold in the first two quarters of contract year four. The survey question, “My family got as much help as we

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needed for my child.” has historically hovered around the 80% threshold and in contract year four it is measured 2.5% points below the threshold . Five of the six measures on the adult survey met the minimum threshold in the first two quarters of contract year four. There were improvements seen in all measures and only one measure was below the 80% threshold.

Member satisfaction survey data showed opportunities for improvement related to access to psychiatrist for adults and minors. There is a known national shortage of psychiatrists and this can even be further exaggerated for members and families in living in rural areas. To address this, Magellan has established interventions to assist members in locating a provider. When members contact Magellan to access services, they are assisted to find a provider. If no providers are accessible, Magellan implements ad hoc interventions to ensure access. Magellan also utilizes physician extenders who are also able to prescribe medications.

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

The number of member grievances related to access received for the first two quarters of contract year four was 2, down from a total of 19 grievance regarding access in CY3. When projecting the first two quarter numbers over the entire contract year 4, this represents a significant decrease in number of grievances over previous contract years. Grievances continued to be handled individually and track and trended to identify network or provider deficiencies.

**Limitations**

Magellan’s claims systems does not have the capacity to delineate a claim by the hour of service delivery. Because of this, it is difficult to have an automated tracking and reporting mechanism for urgent and emergent appointment access. In most cases emergent appointment service requests are done by the provider when the member is already in a secure location; however, these can be flagged as non-compliant as a result of how the claim is submitted.

The report only represents two quarters of data due to the shortened contract period ending November 30, 2015. This should be considered when comparing contract year four data to previous reports.

**Next Steps**

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**Lessons Learned**

Access to care is a complex concept to quantify. The measure is often dependent on member self-reports, further complicating the ability to clearly identify where issues exist. Magellan found it necessary to take a

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multifaceted approach when evaluating access to care beyond the original appointment access indicator in order to ensure the measure was comprehensively monitored.

**System-level Changes Made and/or Planned**

Magellan has made progress in expanding the provider network and working to address member's needs related to access to care; however, continued progress is needed. Magellan recommends ensuring timely access to care continues to be a focus of performance improvement activities as Louisiana moves towards integrated medical model in December 2015.

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

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**Project Topic**

Magellan, in partnership with the LBHP, identified "The number of Coordinated System of Care treatment plans (plan of care) with service authorization at first review" as the clinical Performance Improvement Project (PIP) for contract year one. (**Note:** from this point forward, this PIP will be using the term Plan of Care as the appropriate language for the CSoC Program.)

**Rationale for Topic Selection**

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

**Aim Statement**

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

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claims to determine if the services were received prior to the first review and then on a continuous basis.

## **Methodology**

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### **Performance Indicators**

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

This indicator assesses the percentage of members that are enrolled for at least 30 days who have a service authorization within 30 days of the Plan of Care development. The goal for this indicator is 95%.

**Denominator:** Total Number of members enrolled in CSoC for at least 30 days.

**Numerator:** Number of members who have a service authorization within at least 30 days of the Plan of Care development.

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

This indicator assesses the percentage of members that are enrolled for at least 30 days who have received a service within 30 days of the Plan of Care development. The goal for this indicator is 85%.

**Denominator:** Total Number of members enrolled in CSoC for at least 30 days.

**Numerator:** Number of members who received a service within 30 days of the Plan of Care development.

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

This indicator assesses the percentage of members that are enrolled for at least 30 days who have continued to receive at least one service per month. The goal for receiving at least one CSoC service is 100% as defined by the waiver. The goal for HCBS service per month is 70%.

**Denominator (1):** Total Number of members enrolled in CSoC for at least 30 days.

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

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**Procedures**

WAA roster data were matched against the Magellan data system (IP) to identify all CSoC children who were enrolled in CSoC for at least 30 days and received authorization for services. The Magellan data system records all CSoC treatment authorizations as well as the specific service level authorized. The WAA roster data were further matched against claims data to determine the percentage of children who had claims filed for authorized services. The remeasurement timeframes are 3/1/2014 through 8/31/2015 for authorization based indicator one and 3/1/2014 through 5/30/2015 for claims based indicators two and three. All indicators require the CSoC child to be enrolled in a WAA for at least 30 days to be included in the denominator.

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

**Project Timeline**

Data is monitored quarterly. Baseline data was collected in the first contract year (3/1/12-2/28/13). Re-measurement data was collected for the second contract year (3/1/13-3/28/14), third contract year (3/1/14-2/28/15), and fourth contract year (3/1/15-8/31/15).

Event	Timeframe
Baseline Measurement Period	3/1/2013 through 2/28/2014
Interim Measurement Period	Quarterly 3/1/2014 through 8/31/2015
Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Quarterly 3/1/2014 through 8/31/2015
Intervention Implementation	See Interventions below
Analysis of Project Data	Quarterly 3/1/2014 through 8/31/2015
Submission of Final Report	10/15/2015

**Interventions/Changes for Improvement**

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**Barrier Analysis**

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

1. Providers are not aware of need to refer to community based services. If aware, providers may not understand the value of referring members to community resources.
2. Insufficient network access for members to receive required one CSoC services per month.
3. Wraparound Agencies do not have a sufficient mechanism to track service delivery to ensure that CSoC members receive at least one CSoC servicer per month.
4. Providers do not have clear understanding of CSoC services or 1915 (c) waiver requirements.

**Interventions Planned and Implemented**

Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
Onsite Performance Measure Monitoring	A weighted sample based on census is selected for each region's WAA and is audited quarterly using the Waiver Auditing Tool. A sample of 385 members is reviewed annually in an onsite provider review. Providers who do not meet 100% compliance with waiver performance measures are required to submit a CAP.	4	CSoC Data Reporting Manager	August 2013	Established; Will continue through November 2015
	Waiver Performance Measure data are reviewed quarterly by Magellan's Quality Improvement Committee (QIC) and the Department of Health and Hospital's Interdepartmental Monitoring Team to determine if systemic opportunities for improvement are identified. If so, Magellan, in collaboration with the IMT Committee, will utilize the DMAIC (Define Measure Analysis Improve Control) model to conduct barrier analysis and develop interventions. Data is reviewed quarterly to determine effectiveness of interventions and determine next steps.	4	CSoC Data Reporting Manager	August 2013	Established; Will continue through November 2015
	When system performance is less than 86% for any measure, Magellan conducts further analysis to determine the cause and complete a quality improvement project, subject to the review and approval of DHH-OBH.	4	CSoC Data Reporting Manager	February 2015	Established; Will continue through November 2015
POC Interventions	Magellan developed standardized Plan of Care form that meets waiver requirements. It will require WAA's to clearly identify the type, frequency and duration recommended for each service type, which will improve our ability to	1, 3, 4	Children's System Administrator	01/2014	Completed

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Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	capture HCBS utilization (actually provide a check and balance between what was recommended and our claims verifying what was received)				
	IBHA and POC are monitored by Magellan CSoc operations care management team when submitted to ensure that members' needs are addressed. When a member does not have any HCBS authorizations, Magellan provides recommendations for inclusion of HCBS services on the POC.	3, 4	UM Care Managers	01/2014 and Ongoing	Established; Will continue through November 2015
Improve WAA Monitoring Capabilities	Magellan implemented a web based WAA's QI Data Spreadsheet that includes drop down data entry to improve data integrity, which will provide increased data tracking and monitoring of WAA's for this element.	3	CSoc Data Reporting Manager	12/2013	Established; Will continue through November 2015
	Implemented quarterly WAA CSoc Scorecard that includes metrics on Percent of members receiving CSoc and HCBS to increase provider awareness. Metric will be added to the scorecard to track if member receives at least one CSoc service per month.	3	CSoc Data Reporting Manager	7/2014	Established; Will continue through November 2015
	Provide monthly detail claims report to WAA to monitor the services each member receives.	3	CSoc Data Reporting Manager	3/2014	Established; Will continue through November 2015
Provider Trainings	CSoc Wraparound Coaches and Care Managers speak with clinical directors or program directors weekly to provide education on the different provider types and services available to the enrolled members.	1, 4	Children's System Administrator	1/2013 and ongoing (occurs weekly)	Established; Will continue through November 2015
	A formal Affinity call occurs in collaboration in with the OBH CSoc Team every other Wednesday between WAA Executive Directors (Clinical directors and Program Directors), Magellan DOE liaison, Magellan CSoc Team Members, and FSO Executive Director to identify systemic and/or process barriers that may hinder utilization of services and then bring issues to resolution.	1, 4	Children's System Administrator	1/2013 and ongoing (occurs bi-monthly)	Established; Will continue through November 2015
	Provide trainings on Waiver Compliance as needed to enforce adherence with the goals and principles of the CSoc and DHH-OBH. (See detailed training list at the end of the report).	1, 4	CSoc Data Reporting Manager	As needed	Established; Will continue through November 2015
	A formal QI call occurs monthly between Magellan CSoc Data Reporting Team and the WAA QI Managers and Executive Directors to review and resolve any data collection and reporting barriers.	1, 4	CSoc Data Reporting Manager	As needed	Established; Will continue through November 2015

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Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
Grievance Interventions	Monitor member grievances or provider complaints as they are received. Each grievance/complaint is acknowledged and addressed individually. Magellan tracks and trends to identify if multiple grievances are submitted for a provider or region. Magellan’s network department reviews data to determine if network development is needed to improve access for an area/region/service type or if a specific provider requires a corrective action plan to ensure compliance with access standards.	2	QI and Network	March 2012 and ongoing	Established; Will continue through November 2015
	Internal training of Magellan staff on identifying member dissatisfaction (grievances), including those related to access, and reporting grievances in the CART tracking system. Once grievances increase to a level deemed appropriate to the CMC, an initiative will be formed to decrease the level of grievances.	2	Grievance Coordinator	July 2013	Established; Will continue through November 2015
	Contact providers and discuss appointment access standards when member grievance regarding access to care is received.	2	Grievance Coordinator/Network	7/2013 and ongoing	Established; Will continue through November 2015
Provider Access Interventions	Educate providers through network contacts, provider focus groups, and member service contacts to ensure the providers understand and are able to meet the contractual expectations for appointment standards.	2	Network/Member Service/Clinical Staff	6/2013 and ongoing	Completed in March 2015
	E-mail blast reminding all providers of the contractual obligation to access standards and educating them on keeping their practice information updated via the provider website.	2	Network Administrator	11/2013	Completed
	Initiated quarterly survey of a sample of providers to monitor availability of emergent, urgent, & routine appointments. This survey will be administered by the Member Service Representatives who will call on behalf of Magellan using a planned script to inquire regarding availability of appointments related to access type. If survey finds provider does not meet established access standards, a follow-up letter is sent to provider discussing expectations and requesting planned actions to comply with appointment access standards.	2	Member Service Supervisor/QI Manager	6/ 2013 and ongoing	Completed in August 2015

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	Network conducted a survey to providers (non-inpatient) requesting information about their specialties and availability; the network department updated provider records and provider search to ensure accurate provider availability is documented.	2	Network Administrator	12/ 2013	Completed in August 2015
Member Access Interventions	Member Services Representatives will assist members that contact Magellan seeking assistance in obtaining appointment; outpatient support specialists and/or care managers will assist member in secure appointment within established timeframes depending on need (e.g., emergent, urgent, routine).	2	Member Service Staff/Care Manager	6/ 2013 and ongoing	Established; Will continue through November 2015
	Educate members on access standards via member service calls; as part of discussion, reinforce with member that Magellan is available to assist and member should call back if unable to obtain timely appointment.	2	Member Service Staff/ Supervisor	6/2013 and ongoing	Established; Will continue through November 2015
CSoC QI Data Spreadsheet	<p>New reporting methodology was implemented to track if members are receiving services in the type, amount, duration and frequency specified in the plan of care. Data are collected by the Wraparound Facilitator as part of the monthly Child and Family Team Meeting and entered into the CSoC QI Data Spreadsheet. The data are aggregated quarterly and reported in IMT Report 88.</p> <p>Individual and systematic remediation are required for members that do not receive services as needed including:</p> <ol style="list-style-type: none"> <li>1. I did not need those services this month. No remediation plan needed.</li> <li>2. I have a provider but they are not meeting my needs for services this month. Remediation Plan: Wraparound facilitator contacts provider as part of care coordination.</li> <li>3. I have a provider but they are not meeting my needs for services this month. Remediation Plan: Wraparound facilitator helps member pick another provider.)</li> <li>4. There are no providers available for the service I need. Remediation Plan:</li> </ol>	2	CSoC Data Reporting Manager	6/2015 and ongoing	New; Will continue through November 2015

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Category	Intervention	Barriers Addressed	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	Wraparound facilitator submits System Barriers Report to Magellan Health.				
	Implemented process to collect data to determine if members who do not have access to crisis stabilization or short-term respite needed those services and if lack of the services directly caused to admission to a higher level of care. Magellan will aggregate data quarterly and report to DHH-OBH. Magellan will collaborate with DHH-OBH to address barriers to access.	2	CSoC Data Reporting Manager	9/2015 and ongoing	New; Will continue through November 2015

**Results**

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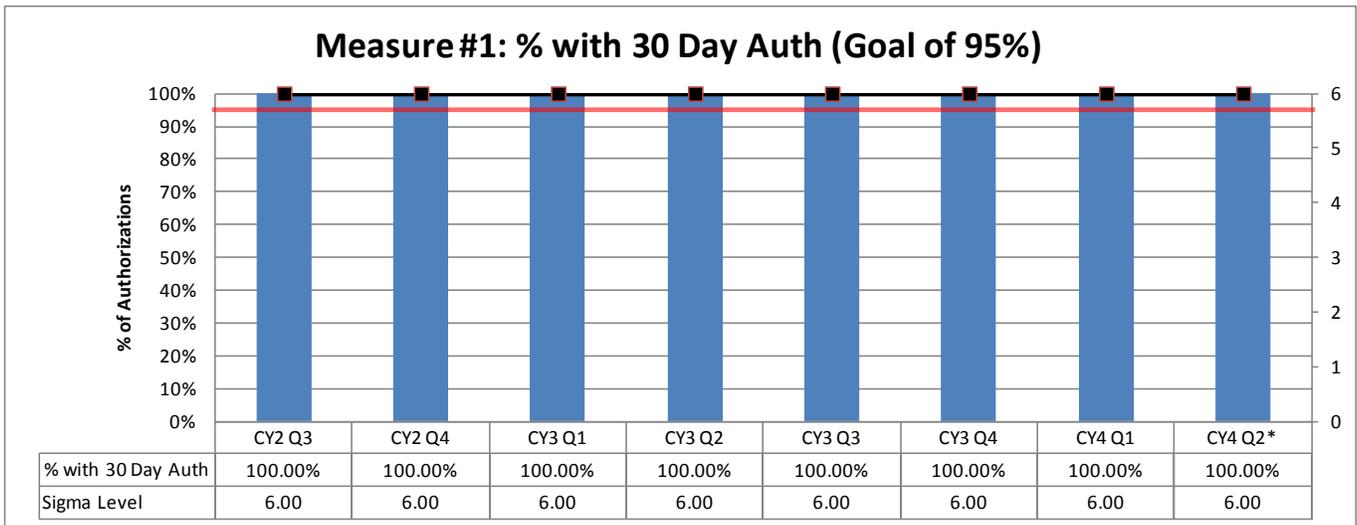
**Indicators 1 and 2 for CY1 to CY4**

Time Period	Denominator	Numerator	% with 30 Day Auth	Sigma Level	Denominator	Numerator	% With Claims < 30 Days for Any Service	Sigma Level
CY 1	1,168	1,115	95.46%	3.19	1,168	1,019	87.24%	2.64
CY 2	1,479	1,418	95.88%	3.24	1,479	1,311	88.64%	2.71
CY 3	1,304	1,304	100.00%	6	1,304	1,216	93.25%	2.99
CY 4*	1,040	1,040	100.00%	6	530	505	95.28%	3.17

\* 30 Day Auths through Q2; Claims through Q

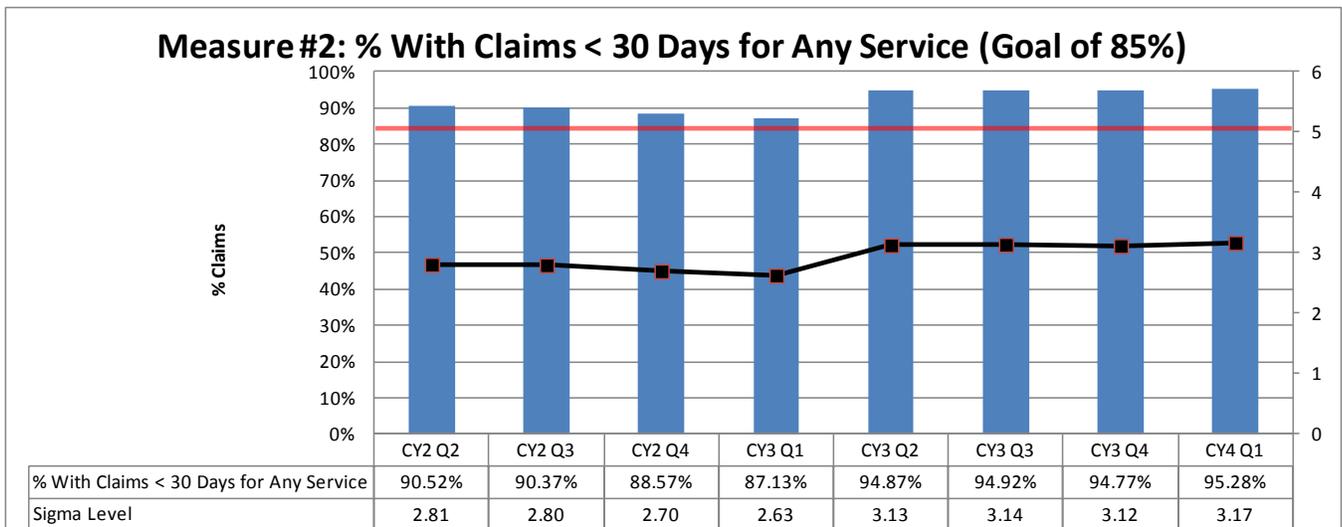
**Indicator 1 Quarterly Rates for CY2 Q3 to CY4 Q2**

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\* 30 Day Auths through CY4 Q2

**Indicator 2 Quarterly Rates for CY2 Q2 to CY4 Q1**

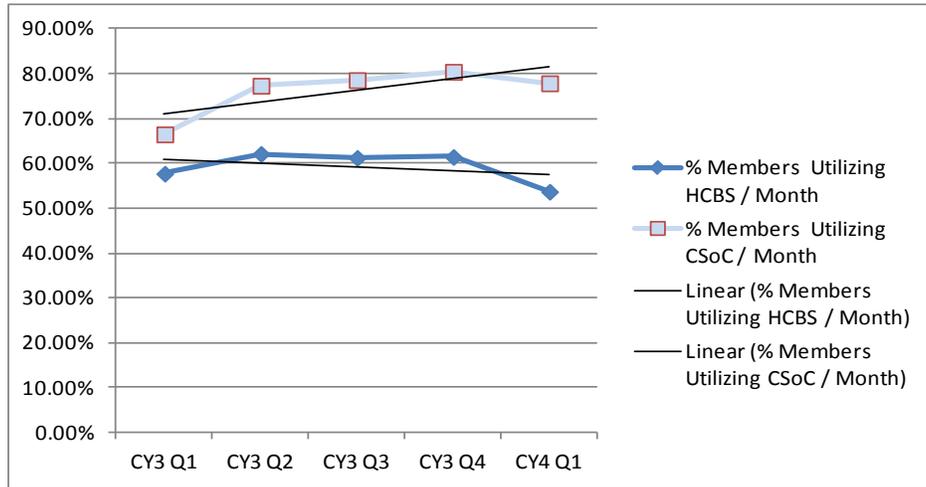


\*Claims through CY4 Q1

**Indicators Three Rates for CY3 Q1 to CY4 Q1**

Time Period	Total Members	Members Utilizing HCBS	% Members Utilizing HCBS / Month	Sigma Level	Members Utilizing CSoC Services	% Members Utilizing CSoC Services / Month	Sigma Level
CY3 Q1	1322	763	57.72%	1.69	879	66.49%	1.93
CY3 Q2	1336	830	62.13%	1.81	1033	77.32%	2.25
CY3 Q3	1432	877	61.24%	1.21	1125	78.56%	2.29
CY3 Q4	1634	1004	61.44%	1.79	1314	80.42%	2.36
CY4 Q1	1929	1129	53.70%	1.72	1658	77.86%	2.58

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**Discussion**

**Discussion of Results**

Magellan showed continued improvements for this project in contract year four. Magellan showed consistent high level of compliance with indicator one. In contract year three, there was a 100% compliance rate for enrolled CSoc members receiving service authorizations within 30 days of the POC review. The indicator obtained a sigma level of 6 out of 6 sigma, indicating no defects in the process. For the first two quarters of contract year four, the compliance rate for enrolled CSoc members receiving service authorizations within 30 days of the POC review was maintained at 100% with no defects in the process. Since contract year two, the compliance rate for enrolled CSoc members receiving service authorizations within 30 days of the POC, has exceeded the established goal of 95%. This reflects that Magellan’s internal utilization management process has consistently met high standards for providing authorizations for services in a timely manner.

Indicator two for receiving a service within 30 days of the POC showed steady improvement since the initiation of the project and increased from 87.24% in contract year one to 93.25% in contract year three; this represented 6.9% increase. For quarter one of contract year four, the compliance rate remained very high at 95.28%. The indicator 2 metric exceeded the established goals of 85% for contract year three and quarter one of contract year four.

The third indicator for continued receipt of services showed improvements as well; however, continued improvement is needed to achieve established goals. The number of members receiving HCBS services was 16.3 percentage points below the goal of 70% and the number of members receiving CSoc services was 22.14 percentage points below the goal of 100%. There was a 17.1% increase in members receiving at least

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one CSoC service per month from contract year three quarter one to contract year four quarter one. The improvement is believed to be attributed to the provider interventions implemented with the Family Support Organization. Magellan will continue to focus future interventions on the FSO and collaborate with the OBH CSoC team to address barriers to accessing CSoC services. There was a 6.4% decrease from contract year three quarter one to contract year four quarter one in members receiving at least one HCBS service per month. This is believed to be affected by the claims lag for HCBS services. Although the goals for this indicator were not achieved, both metrics showed increased sigma levels showing a statistical representation of improvement.

### **Limitations**

The report only represents two quarters of data due to the shortened contract period ending November 30, 2015. This should be considered when comparing contract year four data to previous reports.

Although successes were realized through this project in increasing access to timely services, opportunities for continued network expansion exist. Throughout the contract, Magellan has worked with DHH-OBH to address barriers to the network development of two CSoC services, Crisis Stabilization and Short-Term Respite. In September 2015, Magellan implemented enhancements to CSoC QI Data Spreadsheet to better track unmet needs for these services and if the lack of services led to admissions to higher levels of care. Magellan will monitor this data quarterly and report to DHH-OBH in a continued effort to address barriers.

### **Next Steps**

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### **Lessons Learned**

In the Annual External Quality Review (EQRO) Performance Improvement Project (PIP) Reports for Contract Year Three prepared by IPRO on behalf of the DHH-OBH, IPRO noted that the reported Year 1 results for Indicator 2 differed significantly from the results on the prior Year 2 report, as follows: 89.89% (42.6% prior year report). Magellan conducted validation activities and determined the result reported in the Year 1 report (42.6%) represented only the CSoC services rather than any service. Magellan further reviewed the reporting methodology and determined that the time parameter previously reported for any services was within 90 days of the POC development rather than the reported 30 days. The cause for error was attributed to a change in methodology that was not well documented by the original report owner and then not properly communicated at time of transition to a new report owner. Magellan has implemented internal process improvement initiatives to reduce likelihood of future errors, including enhanced quality assurance activities at the initiation and transition of reports. The correction did not cause significant changes (i.e., at the greatest < 5 percentage points)

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to the previously reported rates and all corrected rates exceeded the 85% goal. Magellan provided OBH-DHH an addendum report for contract year one through three with corrected data and action plan for internal improvement activities. All indicators in this report use the correct methodology.

**System-level Changes Made and/or Planned**

Magellan will continue to work towards enhancing the CSoC network to improve accessibility of services for members. Magellan will notify DHH of any WAA or FSO member access barriers related to certification or otherwise. Magellan will collaborate with DHH-OBH to address any access barriers that may impede member access, which may include, but may not be limited to, OBH completing a needs assessment and collaborating with Magellan to mitigate any identified deficiencies. Other anticipated systematic changes include adding crisis stabilization to the state plan, which allows all Medicaid children to access this service. When this occurs, Magellan will collaborate with the MCO to further develop crisis stabilization services.

Magellan will collaborate with DHH-OBH to identify a PIP for implementation for the CSoC PIHP contract. If the project continues into the CSoC PHIP Contract, Magellan recommends increasing the goal for indicator two from 85% to 95%.

**C. Transitional Care**

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**Project Topic**

Industry and national behavioral health care standards place a high priority on the assurance of continuity of care for all members, and particularly high risk members, when they transition from inpatient to ambulatory care (HEDIS®, AMBHA; NCQA; AAHC/URAC). The transition period between care settings is a vulnerable time for patients and families. Risks for returning to inpatient care are the greatest in the immediate period following discharge, but gradually flatten out over time (Appleby, Desai, Luchins, Gibbons, & Hedeker 1993; Schoenbaum, Cookson, & Stelovich, 1995). Members discharged from inpatient treatment who fail to have adequate aftercare may be at risk of requiring readmission to inpatient treatment, resulting in inappropriate utilization of high-cost inpatient services and under-utilization of appropriate outpatient services (Kruse & Roland, 2002 and Fernando et al., 1990). Transitional care (from hospital to home) is a critical component of care in behavioral health settings should begin with the discharge facility.

**Rationale for Topic Selection**

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

### **Aim Statement**

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

### **Methodology**

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#### **Performance Indicators**

##### **A. Indicator One: Components of Discharge Management Planning**

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

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

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

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

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

**Note:** Reviewing the medication profile must include:

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

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

**D. Indicator Two: Ambulatory Follow-Up Visits After Hospitalization**

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

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

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

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

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

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

This indicator assesses the percentage of inpatient readmissions for mental health and substance use diagnoses. There was a change to the methodology for calculating readmission rate for contract year four. Third party liability members were excluded from the denominator.

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

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

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

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

**F. Indicator Four: Bridge on Discharge Program**

**1. Indicator 4A: BOD Utilization**

**Numerator:** Discharges with a bridge visit

**Denominator:** Facility discharges

**2. Indicator 4B: BOD FUH Rates**

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

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

**3. Indicator 4C: BOD Readmissions**

**Numerator:** Number of readmissions within 30 days

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

**2. Procedures**

**A. Indicator One:** The QM department randomly selects two to four inpatient providers monthly for participation in the Treatment Record Review process. Documentation is reviewed against quality standards for discharge planning to determine compliance. Data are collected quarterly either via an onsite or a desktop audit. Magellan data are entered into corporate web-based auditing tool that provides aggregate and itemized reports. Magellan has a national minimum standard of 80% compliance rate for Treatment Record Reviews. The indicator goal is for all metrics to exceed the 80% minimum performance threshold.

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

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

**C. Indicator Three:** Metric derived from Actuate (Enterprise) Report 22A. The report is based on Integrated Product (IP) data that provide psychiatric inpatient to psychiatric inpatient readmission rates for the specified time period. Inpatient admissions that take place within 48 hours of the discharge are considered transfers and are not included in this report. Indicator goal is for the total readmission rate to not exceed 12%. The Disorder Type is determined as:

- MH (Mental Health) when the diagnosis code is 290.xx, 293.xx to 302.xx, and 306.xx to 316.xx.
- SU (Substance Use) when the diagnosis code is 291.xx to 292.xx and 303.xx to 305.xx.

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- Other includes UNK (Unknown) when the diagnosis code is 799.xx or <NULL> or MED for all other diagnosis codes.

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

**3. Project Timeline**

Event	Timeframe
Baseline Measurement Period	Indicator 1 and 4: March 2014-February 2015 Indicators 2 and 3: March 2013– February 2014
Interim Measurement Period	Quarterly January 2014 – December 2014
Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Indicators 1, 3, and 4: Quarterly March 2014-February 2015 Indicator 2: Quarterly January 2015-May 2015
Intervention Implementation	March 2013-February 2015
Analysis of Project Data	Quarterly March 2014-August 2015
Submission of Final Report	October 15, 2015

**Interventions/Changes for Improvement**

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**1. Barrier Analysis**

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

**A. Practitioner and Facility Barriers**

- 1) Failure of facilities to discuss discharge planning in a timely manner (e.g., at the initiation of treatment).
- 2) Lack of facility staff and/or practitioner understanding of ambulatory follow-up standards (e.g., appointments should include an appointment date and time to improve member compliance, appointment should be made within 7 days of discharge, etc.)
- 3) Lack of coordination of care between inpatient and ambulatory providers
- 4) Lack of provider availability within the appointment timeliness standards.
- 5) Lack of an organized screening in the MH inpatient setting for substance use disorders leading to relapse following discharge from treatment

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- 6) Lack of medication assisted treatment for members with substance use disorders to assist with cravings leading to relapse following discharge from treatment

**B. Patient-Specific Barriers**

- 1) Refusal by patients to accept ambulatory follow-up appointments (often due to denial concerning their behavioral healthcare needs or to lack of insight into their illness).
  - This is especially relevant for members who have had one hospitalization and no previous behavioral health treatment and non-waiver Adult Medicaid members.
  - For the SPMI population, refusal to higher acuity outpatient services (e.g., ACT).
  - For the non-waiver population, refusal to attend any behavioral health appointments.
- 2) Lack of transportation to ambulatory follow-up appointments.
- 3) Member non-compliance with psychotropic medication because medications do not have appropriate prior authorization at time of discharge and they are unable to get prescriptions filled.

**2. Interventions Planned and Implemented**

Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
Monitoring of Discharge Components and Clinical Practice Guidelines for Substance Use Disorders via Treatment Record Reviews	Magellan's Quality Improvement Department's (QI) Clinical Reviewers conduct treatment record reviews (TRRs) to ensure that documentation and record keeping standards are in compliance with federal, state, and Magellan quality standards for discharge planning and Clinical Practice Guidelines for treatment of Substance Use Disorders (CPG SUD).	A1, A2, A3, A6, A7, B3	QI Clinical Reviewers	March 2012- July 2015	Established; Completed in July 2015
	A random selection of inpatient providers is selected monthly for review or providers are chosen as a result of quality of care concerns reported. Records are reviewed utilizing Magellan's Treatment Record Review Auditing Tool. High volume providers (i.e., those serving 50 or more members) are reviewed at a minimum once every three years. Members who have a	A1, A2, A3, A6, A7, B3	QI Clinical Reviewers	March 2012- July 2015	Established; Completed in July 2015

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Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	diagnosis of Substance Use Disorder will be audited for the CPG SUDS.				
	If a provider does not meet minimum standards (i.e., under 80% for the Magellan TRR), the provider will be required to submit a corrective action plan explaining how they will address deficiencies. Providers that score under 70% on the TRR Tool will be re-audited within 180 days to ensure that deficiencies have been addressed. Providers that continue to not meet minimum standards will be referred to Magellan's Regional Network Credentialing Committee and the provider's status in the network could be affected.	A1, A2, A3, A6, A7, B3	QI Clinical Reviewers	March 2012- July 2015	Established; Completed in July 2015
	TRR data are reviewed quarterly by Magellan's Quality Improvement Committee (QIC) and the Department of Health and Hospital's Interdepartmental Monitoring Team to determine if systemic opportunities for improvement are identified. If so, Magellan will utilize the DMAIC (Define Measure Analysis Improve Control) model to conduct barrier analysis and develop interventions. Data is reviewed quarterly to determine effectiveness of interventions and determine next steps.	A1, A2, A3, A6, A7, B3	QI Clinical Reviewers	March 2012- July 2015	Established; Completed in July 2015
Provider Trainings	Provided resource documents on the Magellan of Louisiana website outlining best practices and tips discharge planning. Discharge summary template was uploaded that addresses each of the required elements. These resources have been promoted during provider trainings as well as during onsite treatment record	A1, A2	QM Administrator	March 2014	Completed; Continued access to resources through November 30, 2015

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Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	reviews.				
	Conducted educational training on discharge planning was provided during the monthly provider call. Providers were given information regarding the development of discharge plans and minimum quality standards.	A1, A2	QM Administrator	August 2014	Completed
High Readmission Inpatient Facilities Quality Meetings	Identify Inpatient providers with high readmission rates (>25%).	A1, A2	UM Administrator	May 2014	Completed
	Conducted multidisciplinary onsite quality meetings with hospital executive staff. Provider data for readmissions, follow-up rates, and ALOS was reviewed. Magellan SME's educated providers on techniques to reduce recidivism. Magellan provided education on Bayou Health formularies and how to conduct prior authorizations to ensure seamless delivery of psychotropic medications upon discharge. Educated IP providers on how to identify 1915(i) eligible members and set up appointments for eligibility screening to take place in hospital to reduce transportation barriers.	A1, A2	CMO and UM, QM, and Network Administrators	May-July 2014	Completed
	Re-evaluate data following visits to identify if improvements are identified. Conduct onsite visits of facilities that do not show improvements (readmission >25%).	A1, A2	CEO and UM, QM, and Network Administrators	October 2014	Completed
High Utilizer Rounds	The top 50 inpatient psychiatric bed day utilizers are chosen quarterly from the most recent running year for inclusion in the group. Rounds are conducted weekly and include several participants across the care management center, including the CMO/Medical Administrator, follow-up team, ICC, Inpatient, Outpatient and Residential Care Managers and Peer Specialists.	A3, B1, B2, B3	UM/CM Care Managers/ Follow Up Specialist	June 2013 Ongoing Quarterly	Established; Completed May 2015

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Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	<p>Cases are prioritized according to inpatient admission status and reviewed by the team for history of inpatient presentation, primary symptomatology, diagnostic category, medical issues, outpatient treatment engagement, and eligibility. Care managers identified specialized needs and implemented interventions to address. Interventions include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Linking members to Independent Assessors for the purpose of establishing 1915(i) eligibility</li> <li>• Assigning members to RCM</li> <li>• Linking members to and coordinating care with community-based service providers</li> <li>• Referring members with medical comorbidities to Bayou Health Plans</li> <li>• Regularly involving Physician Advisors in members' clinical reviews</li> <li>• Using Peer Specialists to help bridge the connection with hard-to-engage members.</li> </ul>				
UM Follow Up Team	<p>Within a few days of discharge from a psychiatric hospitalization, members will receive a call from Magellan to verify the aftercare appointment was scheduled within 7 days of discharge and to inquire if the member plans on attending. If the member indicates no aftercare appointment was scheduled or there exists some barrier to attending, Follow Up Specialist will assist the member to reduce barriers (e.g., set up transportation, find provider who can see patient within timeframe).</p>	A2, A4, B2	Follow-Up Specialist	March 2012	Established; Continued through November 30, 2015.
Improve Coordination of Care via Admissions Team (a sub-division of Magellan's	<p>Researching claims to identify if members admitted to IP have received outpatient services. Create notes to ensure UM/CM staff has the necessary information to coordinate care (e.g., previous</p>	A3	Follow-Up Specialist	August 2014-Ongoing	Established; Continued through November 30

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Follow Up Care Management Team)	IP admissions, demographics, current outpatient providers etc.)				
	Help assist the care managers as well as the UR dept/discharge planners from the hospitals as it pertains to follow up care.	A3	Follow-Up Specialist	August 2014- Ongoing	Established; Continued through November 30
	Contact ACT providers to notify them if any members currently enrolled in ACT were admitted to IP LOC.	A3	Follow-Up Specialist	August 2014- Ongoing	Established; Continued through November 30
	Assisting ACT providers in locating “missing” members. (If an ACT provider has not been able to locate a client they will call in and notify them if they have been hospitalized.)	A3	Follow-Up Specialist	August 2014- Ongoing	Established; Continued through November 30
	Contact HCBS providers to notify them when their clients, who have current authorizations with Magellan, have been admitted to IP care.	A3	Follow-Up Specialist	August 2014- Ongoing	Established; Continued through November 30
	Schedule 1915(i) Independent Assessments as needed for clients to ensure they have access to HCBS if they meet clinical criteria. Referrals to RCM as needed.	B1	Follow-Up Specialist	August 2014- Ongoing	Established; Continued through November 30
Bridge on Discharge Program	This is a step down outpatient service meant to immediately ‘bridge’ gaps between inpatient and ambulatory care and is not a substitute for the community provider of choice. A bridge session is considered part of discharge planning which is begun during inpatient admission with information obtained during inpatient benefit certifications including the insured’s community tenure risk factors. During the inpatient continued stay benefit certification(s) any barriers to community tenure are updated as needed to maintain or re-design the discharge plan. MBH requires that a discharge plan MUST	A1, A2, A3, B2, B3	UM Manager/ Follow Up Specialist Manager	June 2014 Ongoing	Established; Continued through November 30, 2015.

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Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	<p>include a provider name with a date and time. It has been shown that a person with a scheduled service is more likely keep the appointment.</p> <p>The Bridge session must be with a LMHP provider such as a social worker, and occur after the insured has been discharged (discharge orders written by the attending) to a non-inpatient setting, but before the insured, leaves the facility. Bridge sessions take place in the facility's outpatient service area or an office designated by the facility for bridge session, never at bedside. During the bridge session the LMHP provider is to solidify the discharge plan by:</p> <ul style="list-style-type: none"> <li>• Confirm demographic information with the patient and their family. Please obtain a current address and working phone number.</li> <li>• Review Discharge Plan and answer any questions.</li> <li>• Discuss the importance of follow-up and how engagement in aftercare can reduce the chance of readmission.</li> <li>• Discuss the importance of taking medication as prescribed. Give suggestions that can assist with remembering medication such as a medication organizer, alarm, connecting with daily routine, etc.</li> <li>• Discuss possible barriers for keeping the appointments so that Magellan staff can work with the patient on working out this issue (examples: transportation, money for medication, medication until next appointment, comfort level with scheduled provider, etc.).</li> </ul>				

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Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	Bridge on Discharge forms are completed by clinician and faxed to Magellan daily. Magellan reviews form to identify if discharge plan meets specifications. If not, follow up specialists will contact clinician about deficiency.	A1, A2, A3, B2, B3	Follow Up Specialist	June 2014 Ongoing	Established; Continued through November 30
	The Intervention has been implemented in a high volume IP provider (i.e., Brentwood Hospital in Shreveport). Magellan will review quality metrics of members (e.g., attendance of outpatient appointment, readmission rates) receiving BOD to determine if expansion to other providers is meaningful.	A1, A2, A3, B2, B3	UM Manager/ Follow Up Specialist Manager	October 2014 Quarterly	Established; Continued through November 30
	IP utilization data and FUH rates will be analyzed to identify hospitals to expand BOD program and the network department will recruit for participation in program.	A1, A2, A3, B2, B3	QM Administrator/ Network Administrator	November 2014	Established; Continued through November 30
	Implemented expanded BOD program in relevant IP facilities.	A1, A2, A3, B2, B3	QM Administrator/ Network Administrator	Contract Quarter 4 2014-15	Established; Continued through November 30
UM Quality of Care Concern Reporting	UM Care Managers (CMs) work with providers during the current review process to ensure that coordination of care and discharge planning is a part of treatment. CMs ask prompting questions during each review to ensure adequate coordination of care and discharge planning is taking place in real time. If a provider is not responsive, then CMs will submit QOCCs for tracking and trending.	A1, A2, A3, A4	UM CMs	March 2012-ongoing	Established; Continued through November 30
	The QM department reviews the concern to assess the level of severity to ensure the safety and well-being of the individual involved. The CMO or medical representative addresses any urgent clinical issues with the provider to ensure Member safety. The	A1, A2, A3, A4	CMO and UM, QM, and Network Administrators	July 2012-ongoing	Established; Continued until November 30 Established; Continued through November

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Category	Intervention	Barrier	Responsible Party	Start and End Date	Intervention: Established/ New/ Completed
	QOC work group, a multidisciplinary team including the CMO and representatives from the UM, QI and Network departments, then reviews concerns to determine next steps, including identifying whether or not a provider performance inquiry and review are necessary. If so, the review is conducted according to the Provider Performance Inquiry and Review Policy with a report outlining the results of the review being sent to Magellan’s Peer Review Committee, the Regional Network Credentialing Committee (RNCC). If no review is needed, the QOC work group will continue efforts to resolve any issues or problems and track and trend results.				30, 2015.

**Measurements**

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**Indicator One: Components of Discharge Management Planning**

**CY3 and CY4 Totals**

Question	CY3 Total			CY4 Total (Q1 and Q2 only)		
	Total	Met	Rate	Total	Met	Rate
Co-occurring (co-morbid) substance induced disorder assessed	279	274	98.20%	553	530.5	96.21%
Discharge plan included an appointment date and time with mental health transitioning provider. If not, the reason was documented.	279	219	78.50%	86	71	81.67%
Medication profile was reviewed with outpatient provider at time of transition of care.	279	222	79.60%	59	36	65.08%
Medication profile was reviewed with member at time of transition of care.	279	257	92.10%	65	52	79.37%
Discharge summary reflected the course of treatment.	279	259	92.80%	157	139	90.37%

**Indicator Two: Ambulatory Follow-Up Visits After Hospitalization**

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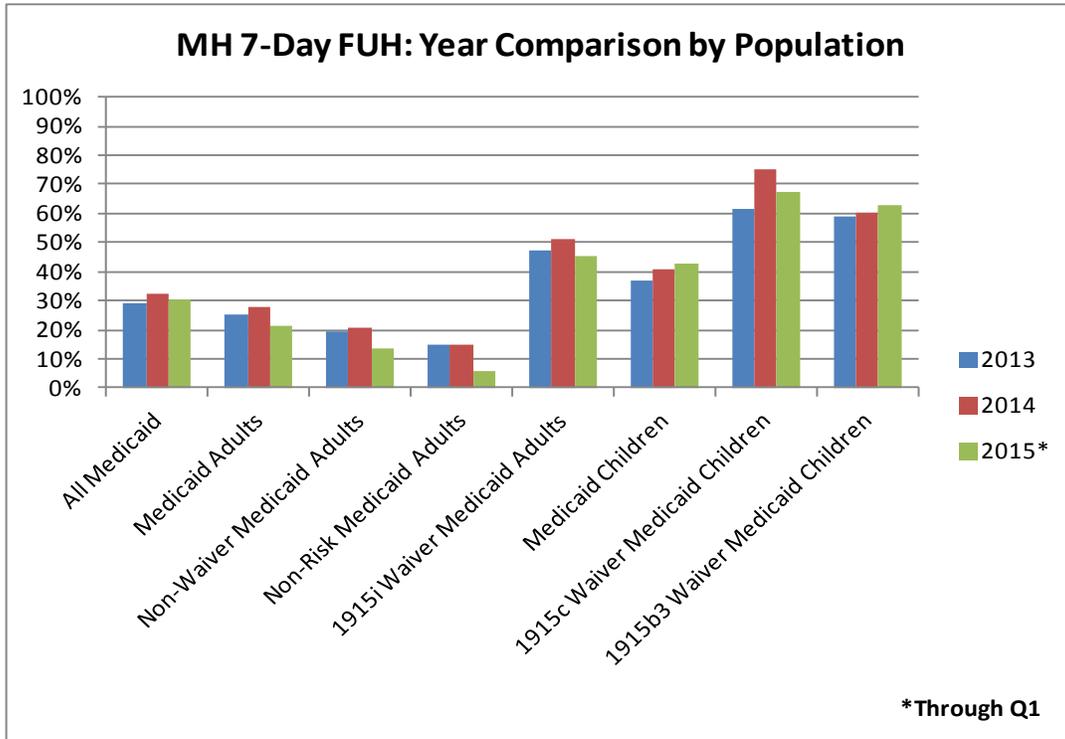
**A. Mental Health**

**HEDIS 2015Q1**

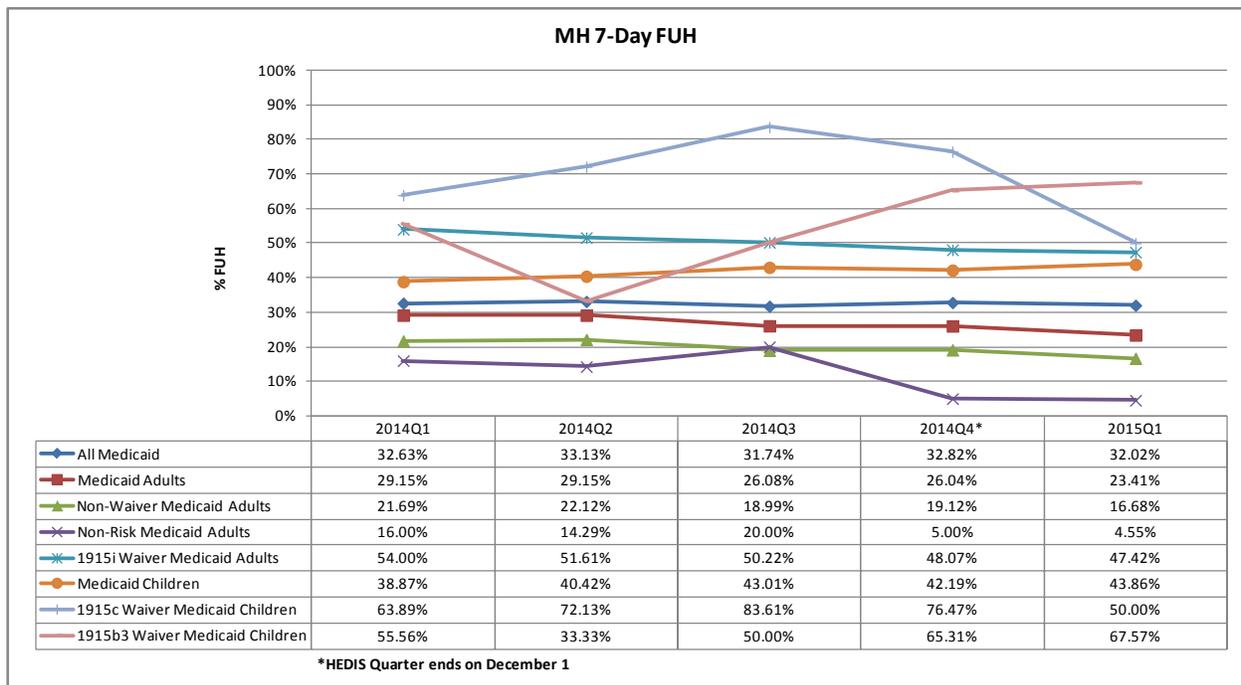
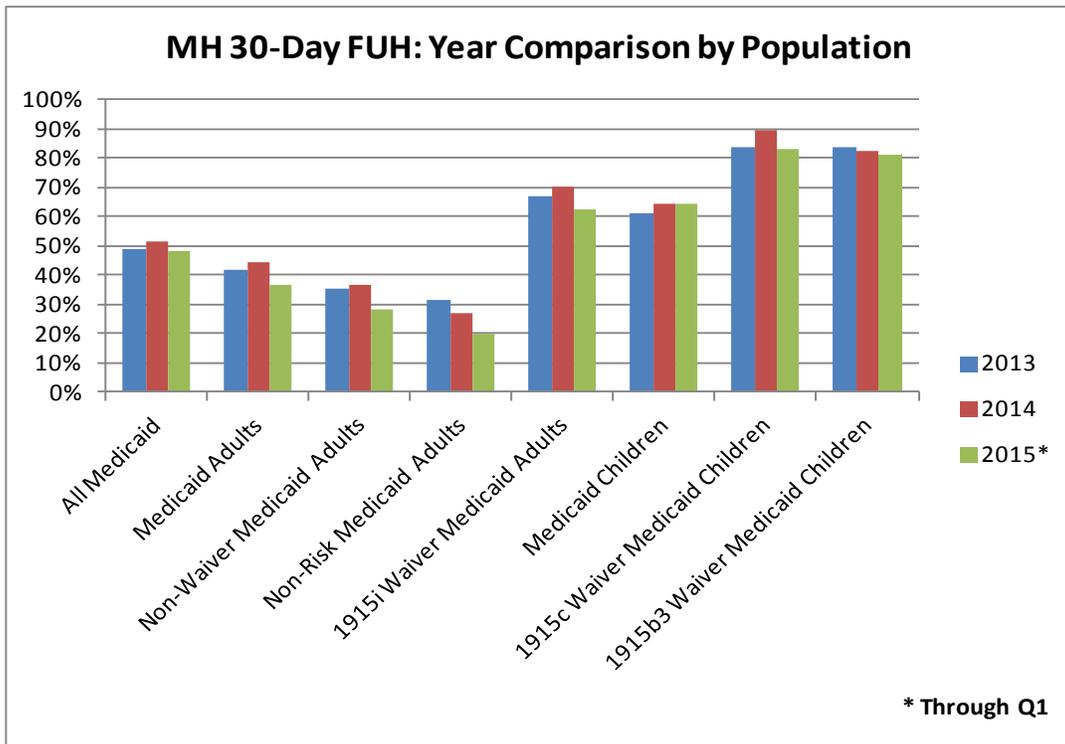
MH FUH: All Medicaid					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	16,586	4,871	29.37%	8,085	48.75%
HEDIS 2014	16,501	5,373	32.56%	8,481	51.40%
HEDIS 2015Q1	4,522	1,448	32.02%	2,343	51.81%
MH FUH: Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	10,713	2,706	25.26%	4,502	42.02%
HEDIS 2014	10,532	2,922	27.74%	4,657	44.22%
HEDIS 2015Q1	2,618	613	23.41%	1,051	40.15%
MH FUH: Non-Waiver Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	8,214	1,591	19.37%	2,892	35.21%
HEDIS 2014	7,903	1,627	20.59%	2,875	36.38%
HEDIS 2015Q1	2,014	336	16.68%	653	32.42%
MH FUH: Non-Risk Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	193	29	15.03%	61	31.61%
HEDIS 2014	142	21	14.79%	38	26.76%
HEDIS 2015Q1	22	1	4.55%	4	18.18%
MH FUH: 1915i Waiver Medicaid Adult					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	2,306	1,086	47.09%	1,549	67.17%
HEDIS 2014	2,487	1,274	51.23%	1,744	70.12%
HEDIS 2015Q1	582	276	47.42%	394	67.70%
MH FUH: Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	5,873	2,165	36.86%	3,583	61.01%
HEDIS 2014	5,969	2,451	41.06%	3,824	64.06%
HEDIS 2015Q1	1,904	835	43.86%	1,292	67.86%
MH FUH: 1915c Waiver Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	80	49	61.25%	67	83.75%
HEDIS 2014	175	131	74.86%	157	89.71%
HEDIS 2015Q1	20	10	50.00%	16	80.00%
MH FUH: 1915b3 Waiver Medicaid Children					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH

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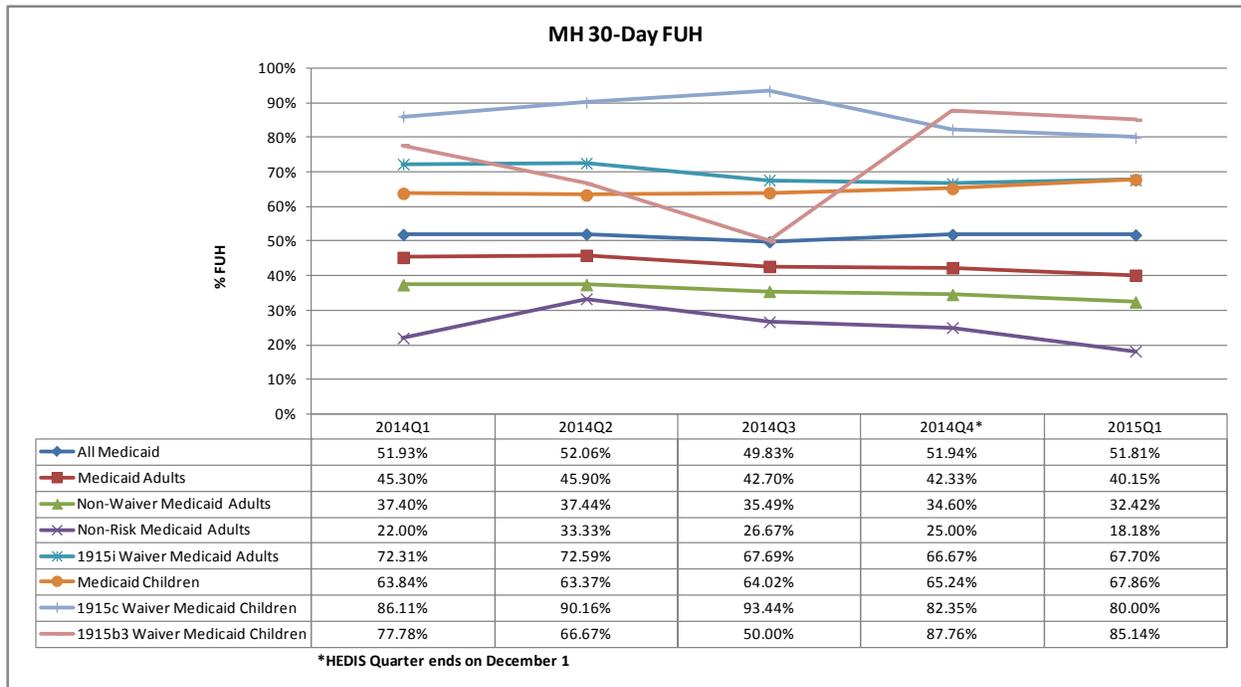
HEDIS 2013	194	114	58.76%	162	83.51%
HEDIS 2014	75	45	60.00%	62	82.67%
HEDIS 2015Q1	74	50	67.57%	63	85.14%
*HEDIS Years end on December 1					



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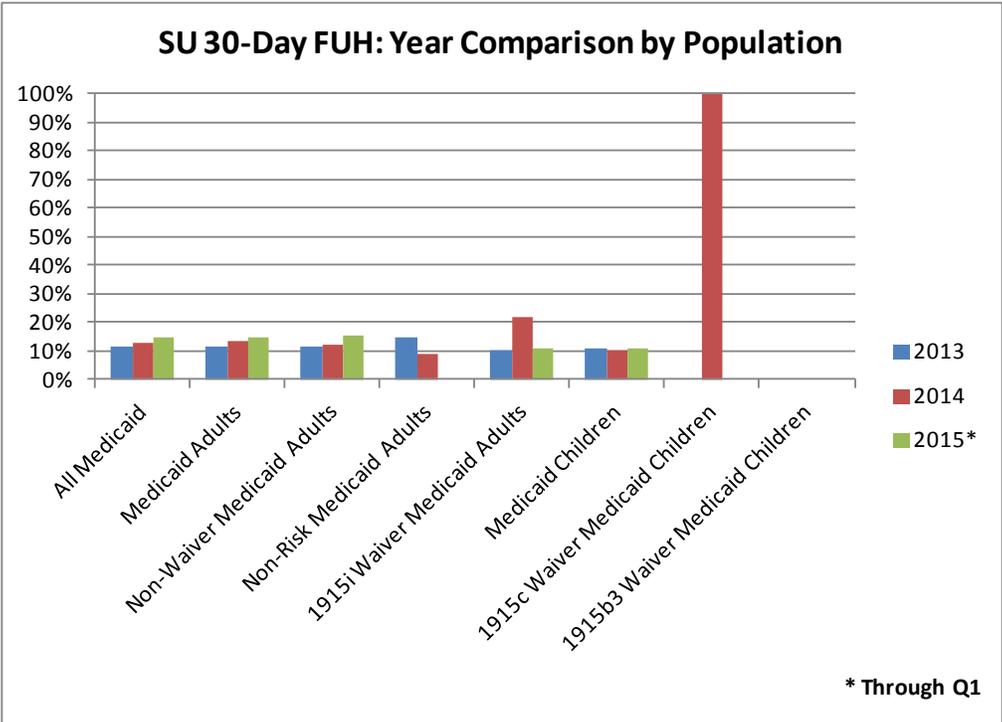
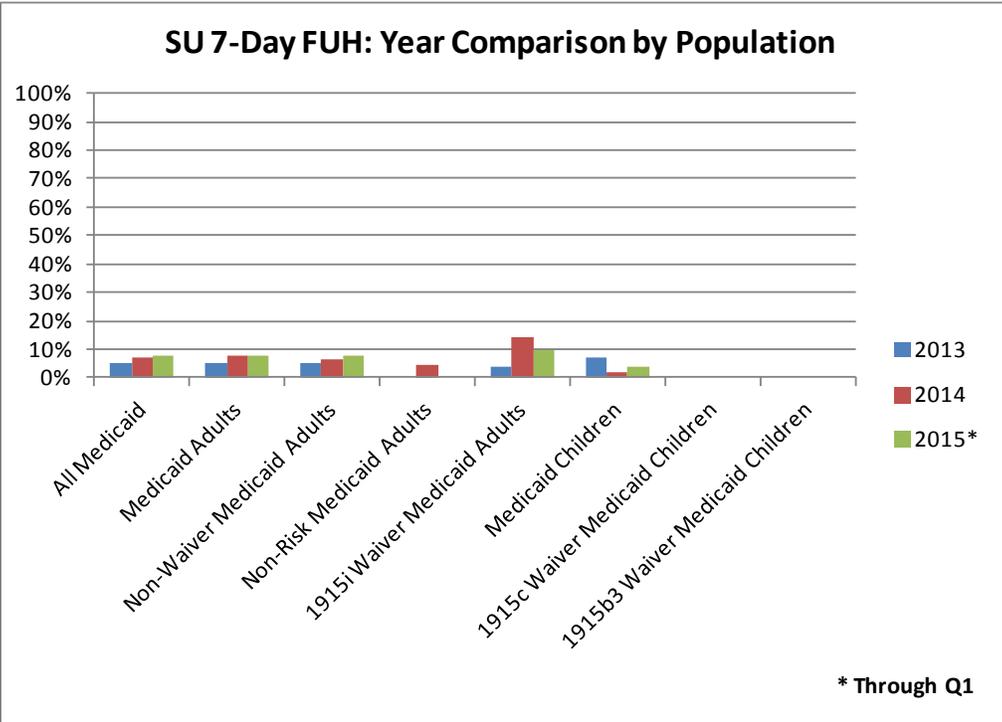
**B. Substance Use Facilities**

SU FUH: All Medicaid					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	1,015	52	5.12%	114	11.23%
HEDIS 2014	976	70	7.17%	127	13.01%
HEDIS 2015Q1	266	26	9.77%	47	17.67%
SU FUH: Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	987	50	5.07%	111	11.25%
HEDIS 2014	919	69	7.51%	121	13.17%
HEDIS 2015Q1	258	26	10.08%	46	17.83%
SU FUH: Non-Waiver Medicaid Adults					
Time Period*	Denom	7-Day Num	7-Day FUH	30-Day Num	30-Day FUH
HEDIS 2013	853	46	5.39%	96	11.25%

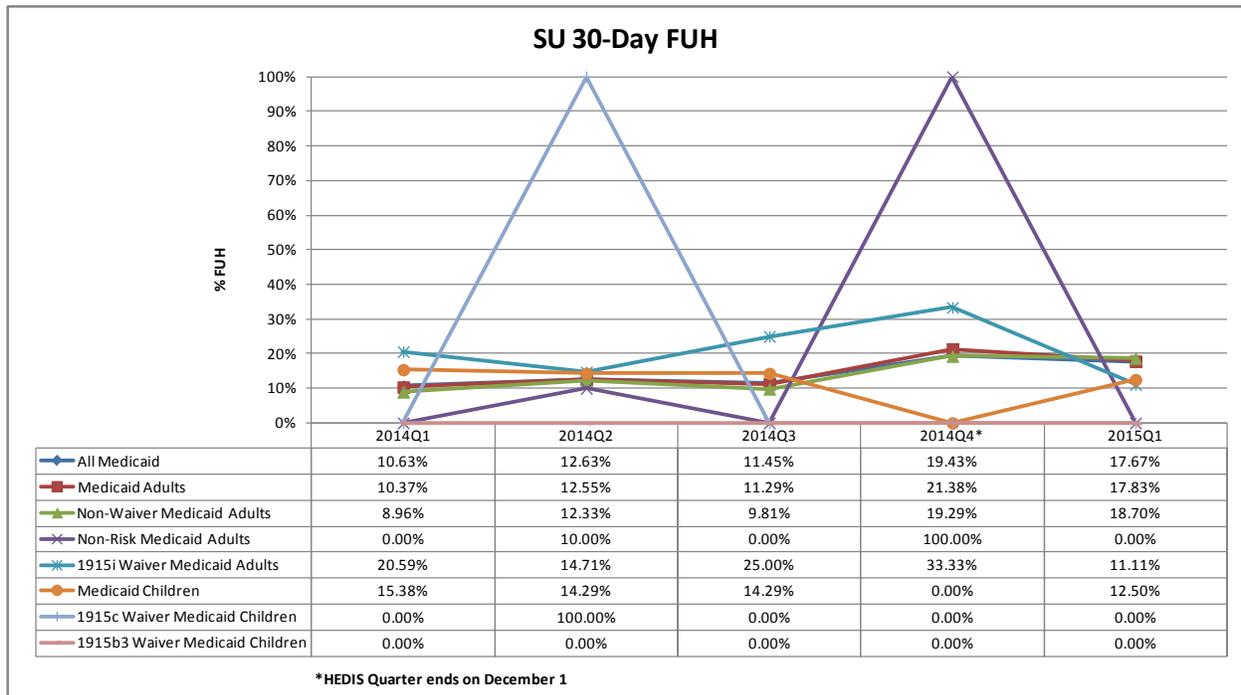
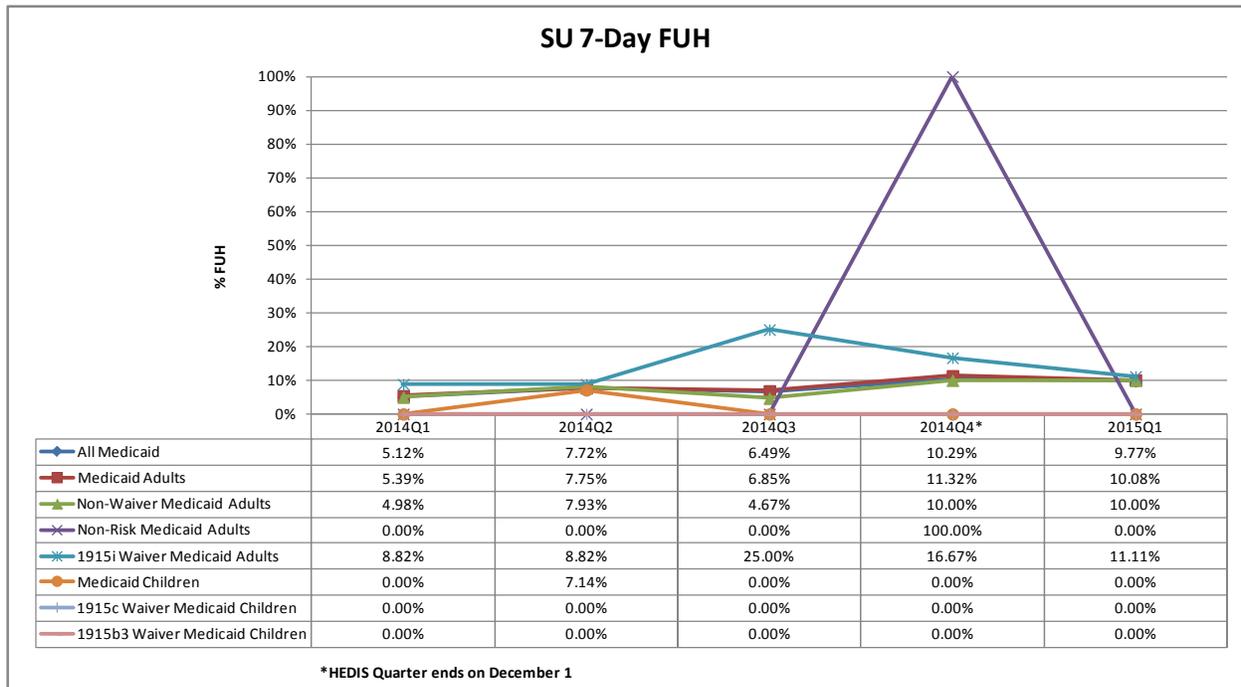
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HEDIS 2014	782	52	6.65%	94	12.02%
HEDIS 2015Q1	230	23	10.00%	43	18.70%
<b>SU FUH: Non-Risk Medicaid Adults</b>					
<b>Time Period*</b>	<b>Denom</b>	<b>7-Day Num</b>	<b>7-Day FUH</b>	<b>30-Day Num</b>	<b>30-Day FUH</b>
HEDIS 2013	34	0	0.00%	5	14.71%
HEDIS 2014	23	1	4.35%	2	8.70%
HEDIS 2015Q1	1	0	0.00%	0	0.00%
<b>SU FUH: 1915i Waiver Medicaid Adult</b>					
<b>Time Period*</b>	<b>Denom</b>	<b>7-Day Num</b>	<b>7-Day FUH</b>	<b>30-Day Num</b>	<b>30-Day FUH</b>
HEDIS 2013	100	4	4.00%	10	10.00%
HEDIS 2014	114	16	14.04%	25	21.93%
HEDIS 2015Q1	27	3	11.11%	3	11.11%
<b>SU FUH: Medicaid Children</b>					
<b>Time Period*</b>	<b>Denom</b>	<b>7-Day Num</b>	<b>7-Day FUH</b>	<b>30-Day Num</b>	<b>30-Day FUH</b>
HEDIS 2013	28	2	7.14%	3	10.71%
HEDIS 2014	57	1	1.75%	6	10.53%
HEDIS 2015Q1	8	0	0.00%	1	12.50%
<b>SU FUH: 1915c Waiver Medicaid Children</b>					
<b>Time Period*</b>	<b>Denom</b>	<b>7-Day Num</b>	<b>7-Day FUH</b>	<b>30-Day Num</b>	<b>30-Day FUH</b>
HEDIS 2013	0	0	0.00%	0	0.00%
HEDIS 2014	1	0	0.00%	1	100.00%
HEDIS 2015Q1	0	0	0.00%	0	0.00%
<b>SU FUH: 1915b3 Waiver Medicaid Children</b>					
<b>Time Period*</b>	<b>Denom</b>	<b>7-Day Num</b>	<b>7-Day FUH</b>	<b>30-Day Num</b>	<b>30-Day FUH</b>
HEDIS 2013	0	0	0.00%	0	0.00%
HEDIS 2014	0	0	0.00%	0	0.00%
HEDIS 2015Q1	0	0	0.00%	0	0.00%
*HEDIS Years end on December 1					

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**Indicator Three: Readmissions to Mental Health and Substance Use Treatment Facilities for the first two quarters of Contract Year Four**

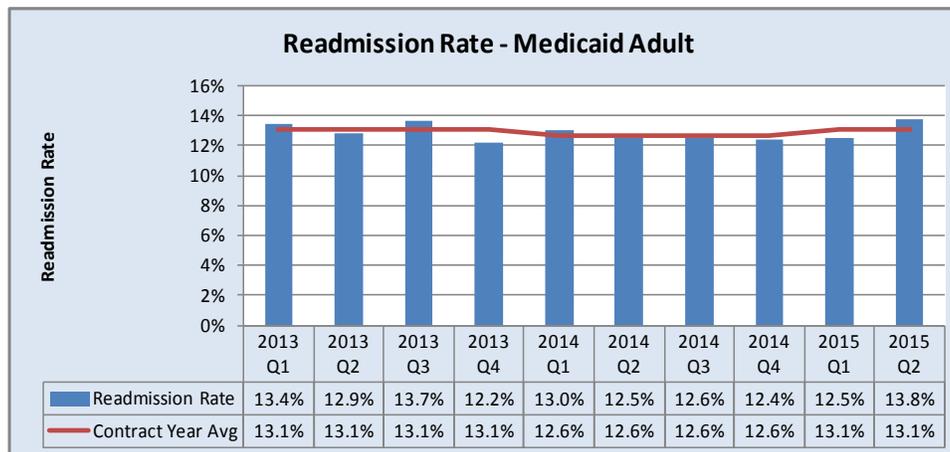
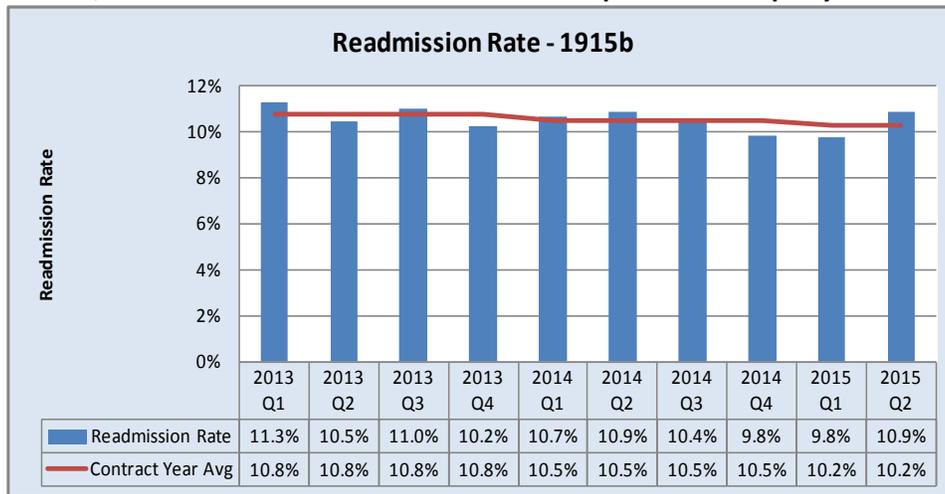
<b>Readmissions</b>				
All Medicaid	<b>Total</b>	<b>MH</b>	<b>SU</b>	<b>Other</b>
	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>
Unique Members readmitted	815	780	33	2
Total unique Discharges	8,602	8,074	512	16
Rate of readmissions	9.47%	9.66%	6.45%	12.50%
<b>Readmissions</b>				
Medicaid Adult	<b>Total</b>	<b>MH</b>	<b>SU</b>	<b>Other</b>
	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>
Unique Members readmitted	532	497	33	2
Total unique Discharges	4,471	3,975	484	12
Rate of readmissions	11.90%	12.50%	6.82%	16.67%
<b>Readmissions</b>				
Medicaid Child	<b>Total</b>	<b>MH</b>	<b>SU</b>	<b>Other</b>
	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>
Unique Members readmitted	259	259	0	0
Total unique Discharges	3,396	3,385	10	1
Rate of readmissions	7.63%	7.65%	0.00%	0.00%
<b>Readmissions</b>				
Non-Medicaid	<b>Total</b>	<b>MH</b>	<b>SU</b>	<b>Other</b>
	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>
Unique Members readmitted	24	24	0	0
Total unique Discharges	671	655	13	3
Rate of readmissions	3.58%	3.66%	0.00%	0.00%
<b>Readmissions</b>				
1915(i)	<b>Total</b>	<b>MH</b>	<b>SU</b>	<b>Other</b>
	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>
Unique Members readmitted	175	173	1	1
Total unique Discharges	1,006	957	46	3
Rate of readmissions	17.40%	18.08%	2.17%	33.33%
<b>Readmissions</b>				
1915(c)	<b>Total</b>	<b>MH</b>	<b>SU</b>	<b>Other</b>
	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>
Unique Members readmitted	26	26	0	0

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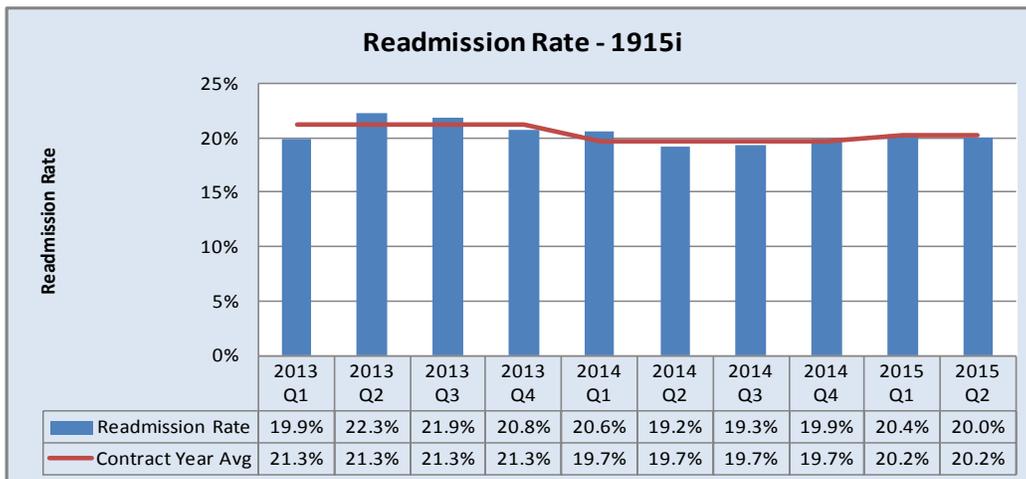
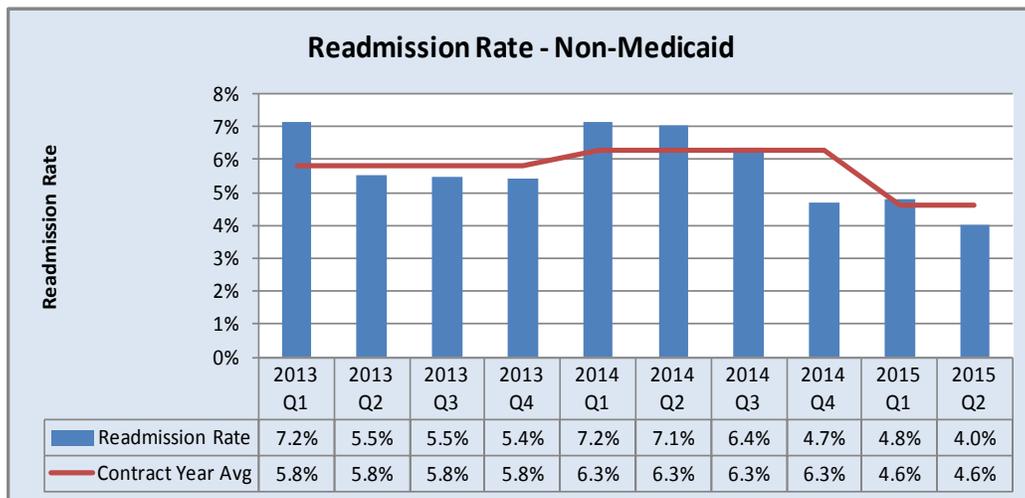
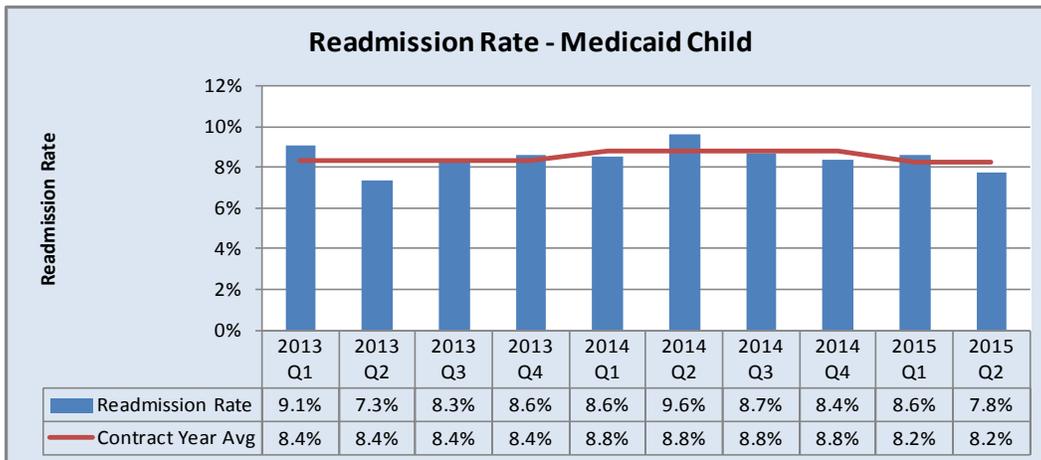
Total unique Discharges	152	152	0	0
Rate of readmissions	17.11%	17.11%	0.00%	0.00%
<b>Readmissions</b>				
1915(b3)	<b>Total</b>	<b>MH</b>	<b>SU</b>	<b>Other</b>
	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>	<b>CY4*</b>
Unique Members readmitted	1	1	0	0
Total unique Discharges	10	10	0	0
Rate of readmissions	10.00%	10.00%	0.00%	0.00%

\* Through Q2; Third Party Liabilities Excluded

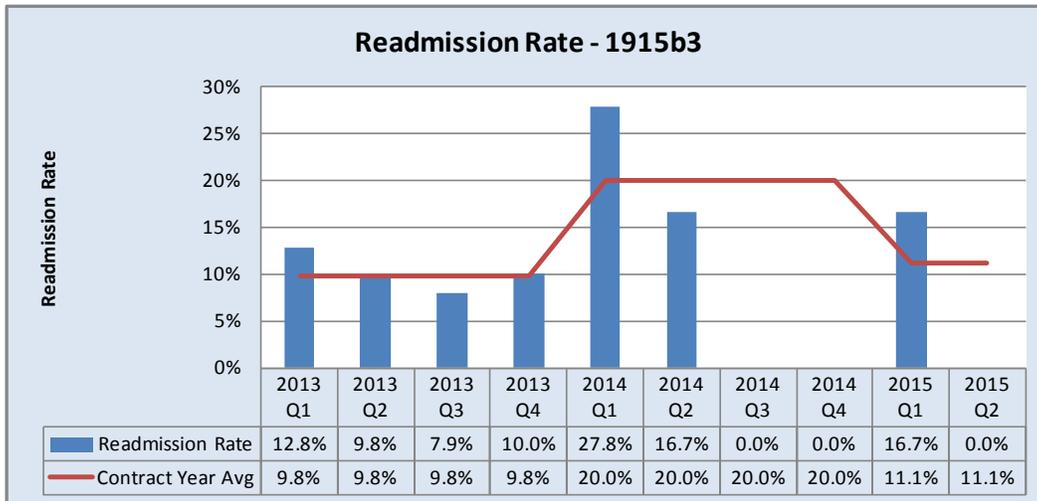
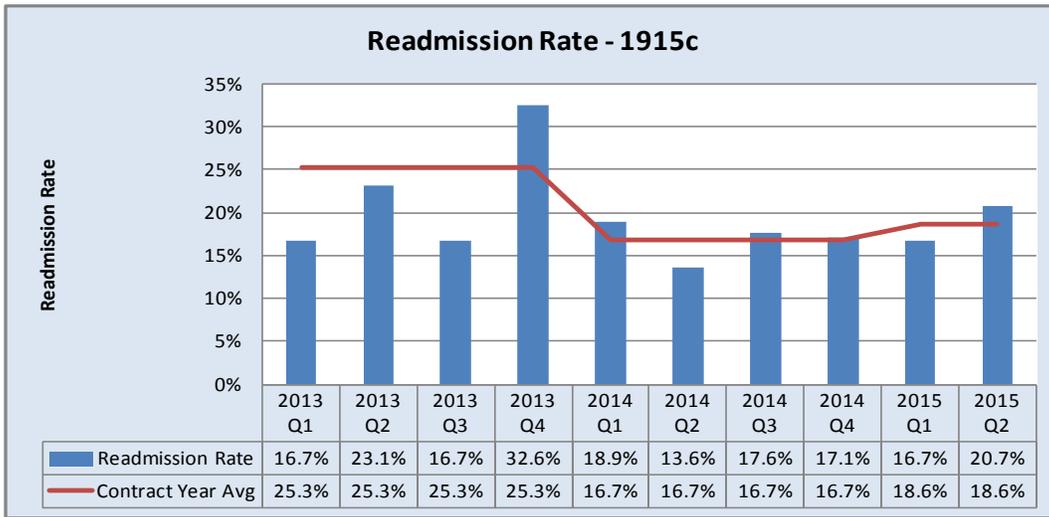
**Contract Year 2013, 2014 and 2015 Readmission Rates for Population Groups by Quarter:**



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**Indicator Four: Bridge on Discharge Metrics**  
**4A: Rate of BOD Appointments**

Contract Year Quarter	2014Q2	2014Q3	2014Q4	2015Q1
Total BOD	253	311	241	224
Total DCs Combined	733	924	858	914
Total Rate of Completion	34.52%	33.66%	28.09%	24.51%
Child BOD	160	237	183	179
Child DCs	440	709	612	693

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Child Rate of Completion	36.36%	33.43%	29.90%	25.83%
Adult BODs	93	74	58	45
Adult DCs	293	215	246	221
Adult Rate of Completion	31.74%	34.42%	23.58%	20.36%

<b>BOD Appointments by Eligibility</b>				
	<b>2014CQ2 Total</b>	<b>2014CQ3 Total</b>	<b>2014CQ4 Total</b>	<b>2015CQ1 Total</b>
<b>Eligibility Population</b>				
Medicaid 1915i Adult	31	19	22	10
Medicaid Non-Waiver Adult	60	53	36	35
Medicaid 1915b3 Child	0	10	19	4
Medicaid 1915c Child	17	10	0	1
Medicaid Non-Waiver Child	143	217	164	174
Non-Medicaid Adult	2	2	0	0
<b>Grand Total</b>	<b>253</b>	<b>311</b>	<b>241</b>	<b>224</b>

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

Combined Population Clinical Metrics

<b>Contract Year Quarter</b>	<b>Population</b>	<b>Number</b>	<b>Readmit % (All) Combined</b>	<b>FUH 7-Day % Combined</b>	<b>FUH 30- Day % Combined</b>
2014Q2	Target	253	18.95%	38.14%	59.79%
2014Q2	Control	373	12.32%	35.74%	56.72%
2014Q3	Target	311	9.18%	44.85%	68.75%
2014Q3	Control	494	10.81%	41.13%	61.23%
2014Q4	Target	241	13.50%	47.55%	71.08%
2014Q4	Control	482	10.54%	33.90%	52.78%
2015Q1	Target	224	8.18%	45.23%	70.35%
2015Q1	Control	583	10.92%	38.43%	59.80%

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Child Population Clinical Metrics

Contract Year Quarter	Population	Number	Readmit % (All) Child	FUH 7-Day % Child	FUH 30-Day % Child
2014Q2	Target	160	14.10%	46.56%	67.18%
2014Q2	Control	228	9.81%	44.97%	66.67%
2014Q3	Target	237	7.69%	51.89%	76.89%
2014Q3	Control	391	8.68%	45.93%	67.44%
2014Q4	Target	183	11.11%	52.50%	75.63%
2014Q4	Control	352	9.94%	40.52%	62.09%
2015Q1	Target	179	7.30%	50.30%	76.36%
2015Q1	Control	437	9.66%	46.43%	70.15%

Adult Population Clinical Metrics

Contract Year Quarter	Population	Number	Readmit % (All) Adult	FUH 7-Day % Adult	FUH 30-Day % Adult
2014Q2	Target	93	27.17%	20.63%	44.44%
2014Q2	Control	145	16.08%	20.69%	40.52%
2014Q3	Target	74	14.08%	20.00%	40.00%
2014Q3	Control	103	18.81%	20.25%	34.18%
2014Q4	Target	58	21.05%	29.55%	54.55%
2014Q4	Control	130	12.20%	14.95%	26.17%
2015Q1	Target	45	11.90%	20.59%	41.18%
2015Q1	Control	146	14.79%	11.86%	25.42%

**Discussion**

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**1. Discussion of Results**

- A. Indicator One:** Components of discharge management planning are monitored to ensure that inpatient providers have an appropriate discharge plan when care is transitioned to an outpatient provider. The goal is for all measures to exceed the 80% minimum performance threshold. Data was gathered for the first two quarters of contract year four and indicated that two of the five measures (i.e., co-occurring substance induced disorder assessed, and discharge summary reflected the course of treatment) exceed the goal with rates greater than 90%. Two measures (i.e., medication profile was reviewed with outpatient provider at time of transition of care, and medication profile was reviewed with member at time of transition of care) had an

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overall rates below the 80% performance threshold. The medication profile was reviewed with member at time of transition of care was slightly below the performance threshold by 0.63 of a percentage point. The medication profile was reviewed with outpatient provider at time of transition of care was below the performance threshold by 14.92 percentage points. Three of the five measures were above the performance threshold in the last two quarters of contract year four. The measure, medication profile was reviewed with outpatient provider at time of transition of care, showed the most opportunity for improvement. Magellan requires providers who fall below 80% for the measures to submit a corrective action plan outlining remediation activities to be implemented to improve compliance. It should be noted that Magellan discontinued record reviews in July 2015 as part of a mutually agreed upon transition plan with the DHH-OBH. Magellan continues to work with inpatient provides during the utilization management process to ensure all members have a discharge plan at time of transition.

- B. Indicator Two:** HEDIS NCQA identify that the 50<sup>th</sup> percentile for MH FUH rates are 46% and 65% for 7 and 30 day rates respectively. In contract year three, the methodology for this metric was adjusted to meet current HEDIS Specifications. The first quarter of the 2015 calendar year metrics, MH FUH rates for the All Medicaid population remained approximately the same as contract year 2014. The 7-Day FUH rate is 13.98 percentage points below the NCQA 50<sup>th</sup> percentile for Medicaid of 46% and is 13.19 percentage points below the national average of 65% for 30 day rate. For the first quarter of the HEDIS 2015 calendar year, Magellan did not reach the goal to meet or exceed 35% for 7 day combined FUH and meet or exceed 55% for 30 day for the All Medicaid population. Medicaid Non-Waiver Adults appear to be negatively impacting overall rates. This population is served by a provider network (i.e., Local Governing Entities) that is not required to submit claims to Magellan. Because this metric is claims-based, this could significantly impact the reliability of the rate for this group. The following populations: 1915(i) Waiver Medicaid Adult, 1915(c) Waiver Medicaid Child, and 1915(b3) Waiver Medicaid Child exceeded the 46% and 65% thresholds for both the 7 and 30 day FUH rate measures. The Medicaid Child population narrowly missed the 46% threshold for the 7-day FUH rate and did exceed the 65% threshold for the 30-day FUH rate.

The first quarter HEDIS 2015 SU FUH rates are lower than MH FUH Rates but also represented a smaller number of members (n=266) compared to MH (n=4,522). The Medicaid Adult population represents the largest segment of this group and show rates lower than the MH FUH (i.e., 7-day: 10.08%; 30-day: 17.83%). This was an improvement over the HEDIS 2014 year. The Non-Waiver Medicaid Adult population also had improved 7-day FUH rate (10.00%) and 30-day FUH rate (18.70%) in the first quarter of the HEDIS 2015 calendar year. Traditionally, the SU population utilizes non-traditional methods for follow-up (e.g., self-help groups) that are not captured in this claims-based metric.

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**Indicator Three:** The goal for readmission measures is to not exceed 12% readmission rate for the All Medicaid population. There was a change to the methodology for calculating readmission rate for contract year four. Third party liability members were excluded from the denominator for contract year four. For trending purposes, the readmission rate charts by contract year quarters did not exclude third party liability readmissions. The combined readmissions rate for mental health and substance use in the total for All Medicaid populations for the first two quarters of contract year four was 9.47%, which 2.53 percentage points, or 26.7% under the performance threshold of 12%. The contract year average for the first two quarters of contract year four of the all Medicaid (1915b) population was 10.2%, 1.8 percentage points below the performance threshold of 12%. The contract year average of the readmission rate for the All Medicaid population continued its downward trend as it has for the past two contract years. The readmission rates rose for the Medicaid adult, 1915i and 1915c population groups and fell for the Medicaid Children, non- Medicaid and 1915b3 population groups.

The population with the highest readmission rate is the 1915(i) population, which includes high risk adult members identified with Serious and Persistent Mental Illness (SPMI). The readmission rate in this group is expected to be higher than the general Medicaid population due to acuity of the membership. The second highest readmission rate group was the 1915(c) population, and for the same reasons as the 1915(i) population, the readmission rate is expected to be higher.

- C. Indicator Four:** The rate of BOD completion has remained steady from contract year three, quarter four to the first quarter of year four. The BOD group had a higher rate of attending 7-day and 30-day FUH when compared to the control group, with the greatest impact in the 30 day rate. The BOD 30 day rate was 10.55 percentage points higher than the control group. The CY4 Q1 BOD readmission rate 1.33 percentage points lower than the control group. The results indicate that the BOD appointment was successful in increasing the likelihood of attending a FUH ambulatory appointment.

## **2. Limitations**

Because the provider network (i.e., Local Governing Entities) that largely serves the Medicaid Non-Waiver Adults is not required to submit claims to Magellan, their inclusion in the follow-up rates may skew the overall rate. It is recommended this population is not included in this indicator in the future. Also River Oaks Hospital was contracted to begin providing Bridge on Discharge (BOD) program appointments in contract year four. They did not implement the program until after the project was discontinued.

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In the Annual External Quality Review (EQRO) Performance Improvement Project (PIP) Reports for Contract Year Three prepared by IPRO on behalf of the DHH-OBH, IPRO noted performance goals for Substance use follow-up appointments should be established. Magellan acknowledges the finding; however, this information was received after the Contract Year Four project was concluded and interventions were not targeted specifically to the Substance Use population. Based on historical data, Magellan recommends goals of 15% for 7-day and 30% for 30-day follow-up appointments should be initially established for the MCOs.

The report only represents two quarters of data due to the shortened contract period ending November 30, 2015. This should be considered when comparing contract year four data to previous reports.

### **Next Steps**

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#### **1. Lessons Learned**

It should be noted that populations that have increased access to home and community based services (e.g., 1915(c) waiver, 1915(i) waiver, Child Medicaid) have consistently shown higher follow up rates as compared to populations with basic Medicaid services (e.g., Non-Waiver adults, non-risk adults). The Bridge of Discharge intervention has also proven to be a successful intervention in increasing member likelihood of attending follow up outpatient hospitals after discharge from an inpatient setting. It is recommended that these two considerations be conveyed to Bayou Health Plans as part of transition plans.

#### **2. System-level Changes Made and/or Planned**

Although progress has been made in improving transitional care, systematic improvements are still needed to meet long term goals. Magellan recommends the Bayou Health Plans consider formally addressing this project topic in the future. Follow up rates for 1915(c) waiver populations far exceed the 50<sup>th</sup> percentile rate for 7-day follow up. Because of this, Magellan does not recommend continuing this project for the CSOC PIHP contract.

#### **D. Improve Adverse Incident Reporting**

##### **Project Topic**

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#### **1. Describe Project Topic**

Accurate adverse incident reporting is an essential component of a quality management program that allows managed care organizations to monitor the safety culture of its providers and identify patient

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safety concerns that require increased oversight. Magellan is also required by contract to track, review, and investigate critical incidents and accidents, morbidities, mortalities, and other quality of care issues. When critical incidents, known as adverse incidents, are received, reports are analyzed for patterns and trends, such as a disproportionate number of a type or category of concern or a high or increasing number of concerns related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, a root cause analysis is conducted and interventions are implemented. The Quality Improvement Committee reviews this information continuously, so improvements to the system can be made on an ongoing basis. In order for this process to be effective, it is essential providers submit reports of incidents to Magellan.

## **2. Rationale for Topic Selection**

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

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

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

It also states that the SMO must have:

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

As the SMO, Magellan Health in Louisiana has established a comprehensive patient safety monitoring process that includes monitoring adverse incidents and quality of care concerns as well as conducting treatment record reviews and provider site visits to monitor operational and clinical practices. A key

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component of this process is dependent on provider reporting therefore it is essential to ensure providers are accurately reporting.

### **3. Aim Statement**

The aim of the PIP is to show statistically significant improvement in adverse incident reporting as evidence by an increase in total number of adverse incidents received.

## **Methodology**

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### **1. Performance Indicators**

#### **A. Indicator One: Number of Provider Reported Adverse Incidents Reported (excluding Restraints and Seclusions)**

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

#### **B. Indicator Two: Number of Provider Reported Restraints and Seclusions**

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

#### **C. Indicator Three: Suicide Rate**

Indicator reports the number of suicides and the suicide rate for the Medicaid eligible population in Louisiana.

#### **D. Indicator Four: Homicide Rate**

Indicator reports the number of homicides and homicide rate for the Medicaid eligible population in Louisiana.

### **2. Procedures**

An adverse incident is defined as an unexpected occurrence in connection with services provided by Magellan, its subsidiaries and affiliates (Magellan), that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, to an individual receiving services through Magellan or a third party that becomes known to Magellan staff.

### **Incident Types**

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Definitions of the types of reportable incidents are documented below:

1. **Death** – All deaths regardless of cause or the location where the death occurred.
2. **Suicide Attempt** – The intentional and voluntary attempt to take one’s own life. A suicide attempt is limited to the actual occurrence of an attempt that requires medical treatment, and/or where the member suffers or could have suffered significant injury or death.  
*Non-reportable events include:*
  - o *Threats of suicide that do not result in an actual attempt*
  - o *Gestures that clearly do not place the member at risk for serious injury or death*
  - o *Actions that may place the member at risk, but where the member is not attempting harm to himself/herself*
3. **Significant Medication Error**– A significant medication error includes an incorrect medication or incorrect dosage, where a member suffers an adverse consequence and receives treatment to offset the effects of the error. Any use of medication that results in member morbidity.  
*Non-reportable events include:*
  - o *Refusal by the member to take prescribed medication*
4. **Event Requiring Emergency Services** (of the fire department or a law enforcement agency) – This includes events such as fires, an individual charged with a crime, an individual who is a victim of a crime, acts of violence, vandalism, or misappropriation of member property.  
*Non-reportable events include:*
  - o *Non-emergency services of the fire department or law enforcement agency*
  - o *Police presence related to commitment procedures or rescue squad activities*
  - o *Testing of alarm systems/false alarms or 911 calls by members that are unrelated to criminal activity or emergencies*
5. **Abuse** –
  - a. **Abuse (child/youth)** – According to the 1915(c) Waiver abuse is defined as any one of the following acts which seriously endanger the physical, mental, or emotional health and safety of the child:
    - i. The infliction, attempted infliction, or as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person,
    - ii. The exploitation or overwork of a child by a parent or any other person,
    - iii. The involvement of the child in any sexual act with a parent or any other person, or the aiding or toleration by the parent or any other person of the child’s sexual involvement with any another person or the child’s involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state.
    - iv. The coercion of a child into having an abortion

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(Children’s Code Article 603)

- b. **Abuse (adult):** According to Adult Protective Services (APS), abuse is defined as follows:
  - i. Physical contact or actions that result in injury or pain, such as hitting, pinching, yanking, shoving, pulling hair, etc.
  - ii. Emotional - threats, ridicule, isolation, intimidation, harassment
  - iii. Sexual abuse of an adult, when any of the following occur:
    - 1. the adult is forced, or otherwise coerced by a person into sexual activity or contact,
    - 2. the adult is involuntarily exposed to sexually explicit material, sexually explicit language, or sexual activity or contact;
    - 3. the adult lacks the capacity to consent, and a person engages in sexual activity or contact with that adult.
- **Note:** An adult is defined by APS as a person over 18 years of age or an emancipated minor.
- c. **Exploitation (adult):** The misuse of someone’s money, services, property, or the use of a power of attorney or guardianship for one’s own purposes.
- d. **Extortion (adult):** The acquisition of a thing of value from a person by physical force, intimidation, or abuse of legal or official authority. (Louisiana Revised Statutes 15.1503.8).
- e. **Neglect (child/youth):** The refusal or unreasonable failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment, or counseling for injury, illness, or condition of the child, as a result of which the child’s physical, mental, or emotional health and safety is substantially threatened or impaired. This includes prenatal illegal drug exposure caused by a parent, resulting in the newborn being affected by the drug exposure or withdrawal symptoms. (Children’s Code Article 603)
- f. **Neglect (adult):** The failure, by a **Care Giver** responsible for an adult’s care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (Louisiana Revised Statutes. 15.1503.10)

**Definitions:**

- **Care Giver** – means withholding or not assuring provision of basic necessary care, such as food, water, medical or other support services, shelter, safety, reasonable personal and home cleanliness or any other necessary care.
- **Self** – means failing, through one’s own action or inaction, to secure basic essentials such as food, medical, care, support services, shelter, utilities or any other care needed for one’s well-being.

*Non-reportable abuse events include:*

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- *Among residents of a treatment/medical facility that may result in physical contact, but do not cause serious injury and that do not reflect a pattern of physical intimidation or coercion of a resident.*
  - *Discord, arguments or emotional distress resulting from normal activities and disagreements that can be found in a typical residential/outpatient treatment program.*
- 6. Injury or Illness** – Reportable injury includes those instances when the member requires medical treatment more intensive than first aid; or, anything that causes unexpected morbidity to the member secondary to the inappropriate treatment rendered. First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages. Reportable illness of a member includes any life-threatening illness or any involuntary emergency psychiatric admission that occurs as the result of a residential provider’s initiation.
- Non-reportable events include:*
- *Scheduled treatment of medical conditions, on an outpatient or inpatient basis*
  - *Any voluntary inpatient admission to a psychiatric facility, or service at a crisis facility or psychiatric department of acute care hospitals for the purpose of evaluation and/or treatment*
  - *Emergency room (ER) visits or inpatient admissions that result from a member’s previously diagnosed chronic illness, where such episodes are part of the normal course of the illness*
  - *ER visits where the visit is necessitated because of the unavailability of the member’s primary care physician.*
- 7. Missing Person** – Residential/Inpatient providers are to report a member who is out of contact with staff, without prior arrangement, for more than 2 hours. A person may be considered to be in “immediate jeopardy” based on his/her personal history and may be considered “missing” before 24 hours elapse in a community setting. Additionally, it is considered a reportable incident whenever the police are contacted about a missing person, or the police independently find and return the member, regardless of the amount of time he or she was missing.

### **Adverse Incident Reporting**

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

### **Reporting Requirements**

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

- For the following types of events, submit a report if the event occurs **while in the provider’s care**:

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- Significant medication error, need for emergency services, serious injury or illness, missing person, seclusion or restraint.
- For the following types of events, submit a report **regardless of where it occurs**:
  - Death, Suicide Attempt, Abuse, Neglect, or Exploitation.

### **Internal Processing of Incidents**

Adverse Incident Reporting forms are faxed by providers to a Quality Improvement fax box. The Adverse Incident/ Quality of Care Clinical Reviewer monitors the fax box every business day. All adverse incidents are entered into the Quality Improvement System for tracking purposes. Each incident is reviewed and investigated to determine if there is dangerousness associated with the incident. If dangerousness is identified, all efforts are made to ensure the safety of member/s affected. The Chief Medical Officer is consulted for all serious incidents to determine an appropriate action plan (e.g., onsite review, record review). Results of the investigation are presented to the Regional Network Credentialing Committee (RNCC), a provider peer committee. If the incident involves any one of our state partners (e.g., Department of Children and Family Services and/or the Office of Juvenile Justice), they are notified within 24 hours of Magellan's awareness of the incident and the established collaborative protocol is followed. If the incident is severe enough, it is immediately taken to the RNCC for approval of action steps (e.g., placing provider on hold, terminating provider from network). The data are aggregated monthly and reported to the RNCC monthly and the Quality Improvement Committee quarterly. Provider terminations are reported through the Network quarterly reporting package. If the termination results in a material change in the network, Magellan provides written notice to DHH-OBH, no later than seven (7) business days of the network provider contract termination. Magellan conducted analysis using the paired t-test to determine if statistically significant improvement is seen between Contract Year 2 and Contract Year 3 for total number of reports received by all providers and total number of reports by inpatient providers.

### **B. Indicator Two: Number of Provider Reported Restraints and Seclusions**

The Restraints and Seclusions are tracked using the following definitions:

- *Seclusion* is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.
- *Chemical restraints* consist of one time as needed medications which restricts the freedom of movement or causes incapacitation by sedation. This does not include the use of standing PRN dosages.
- *Physical or Mechanical Restraint*—any physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

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Providers are to report any use of seclusion or restraint (chemical, mechanical and physical). Providers are required to report all incidents of restraint and seclusion use that result in injury within the defined Adverse Incident reporting timeframes. Restraints and seclusions that do not result in injury are tracked independently. The following data for all other incidents of restraint and seclusion use are to be submitted by providers monthly, no later than the 5th of each month:

- Number of episodes or seclusion and restraint use for the previous month
- Number of hours of seclusion and restraint use for the previous month
- Number of persons in seclusion and restraints for the previous month
- Total number of Medicaid members served for the previous month

**C. Indicator Three: Suicide Rate**

Suicides are reported according to the indicator one procedure.  
The rate of suicide is calculated at the rate per 100,000.

This Indicator was added in contract year four because there is currently not a mechanism to compare adverse incidents reported for the Medicaid population in Louisiana to other states. Magellan included this measure to compare Louisiana’s incidents of suicide to the national average, which was established through the Center for Disease Control and Prevention (CDC).

**D. Indicator Four: Homicide Rate**

Homicides are reported according to the indicator one procedure.  
The rate of homicide is calculated at the rate per 100,000.

This Indicator was added in contract year four because there is currently not a mechanism to compare adverse incidents reported for the Medicaid population in Louisiana to other states. Magellan included this measure to compare Louisiana’s incidents of homicide to the national average, which was established through the Center for Disease Control and Prevention (CDC).

**3. Project Timeline**

Data is monitored quarterly. Baseline data was collected in the second contract year (3/1/13-2/28/14). Re-measurement data includes time parameters through contract year four (3/1/14-8/31/15).

Event	Timeframe
Baseline Measurement Period	3/1/2013 through 2/28/2014
Interim Measurement Period	Quarterly 3/1/2014 through 8/31/2015

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Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Quarterly 3/1/2014 through 8/31/2015
Intervention Implementation	See Interventions below
Analysis of Project Data	Quarterly 3/1/2014 through 8/31/2015
Submission of Final Report	10/15/2015

**Interventions /Changes for Improvement**

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**1. Barrier Analysis**

Barriers affecting provider reporting of adverse incidents includes:

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

**2. Interventions Planned and Implemented**

The below initial interventions are focused on taking a collaborative and educational approach with providers to address the barrier that providers are unaware of the reporting requirements or are not reporting. The interventions (except the treatment record review) are based on provider integrity as they require self reporting. Intervention status is included to account for changes related to the transition plan and the contract end date. The Enhanced Reporting intervention was added to increase value of reporting to DHH-OBH, but it does not necessarily address barriers to reporting.

Category	Intervention	Barrier	Responsible Party	Date of Implementation	Intervention Status
Provider Trainings Interventions	Include the Critical Incident reporting requirements in Provider Orientation Training	1,4	Network Trainer	October 2014 – May 2015	Discontinued in August 2015
	Conduct network refresher trainings to ensure providers are aware of reporting requirements, procedure and definitions.	1,4	AI/QOC Coordinator	October 2014	Discontinued in August 2015
Treatment Record Reviews	Add an element on the TRR auditing tool to track if AI protocol was used if adverse incident is documented in record.	1,2,3,4	QI Reporting Manager	September 2014 – July 2015	Discontinued in July 2015
	Conduct internal training of Clinical Reviewer staff to ensure consistent understanding of Critical Incident Definitions and provide training on the	1,2,3,4	AI/QOC Coordinator	September 2014	Discontinued in July 2015

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Category	Intervention	Barrier	Responsible Party	Date of Implementation	Intervention Status
	scoring guidelines for new AI TRR auditing item.				
	Random sample of records from providers from all LOCs are requested monthly (beginning in 3/2015 high volume providers will be reviewed once every 2 years) is selected.	1,2,3,4	QI Manager	November 2014- July 2015	Discontinued in July 2015
	Magellan will review records using TRR Auditing Tool. If critical incident is identified, then Magellan will coordinate with AI/QOC coordinator to ensure it was reported through established process and score TRR item appropriately.	1,2,3,4	QI Clinical Reviewers; AI/QOC Coordinator	November 2014 – July 2015	Discontinued in July 2015
	If provider did not report, AI/QOC coordinator will determine if provider has a reporting history.	1,2,3,4	QI Clinical Reviewers; AI/QOC Coordinator	November 2014 – July 2015	Discontinued in July 2015
	If provider has no previous history of interventions, CR will provide education and request provider to sign attestation stating that they understand and will adhere to Magellan’ critical incident reporting protocol.	1,2,3,4	QI Clinical Reviewers	November 2014 – July 2015	Discontinued in July 2015
	If provider has a history of previous interventions, corrective action plan will be required that will be monitored by the Regional Network Credentialing Committee.	2,3	QI Clinical Reviewers	November 2014 – July 2015	Discontinued in July 2015
	If provider is not responsive to Corrective Action Plan (CAP), the RNCC will determine next steps (e.g., placing provider on hold from accepting new members, termination) based on review of actions.	2,3	CMO	January 2015- July 2015	Discontinued in July 2015
Grievances and Quality of Care Interventions	Magellan will review all reports submitted through the grievance and quality of care process.	1,2,3,4	Grievance Coordinator; AI/QOC Coordinator	October 2014	Established; Will continue until November 2015
	If a critical incident is identified, Magellan will review critical incident data to determine if report was submitted by the involved provider using the established protocol.	1,2,3,4	AI/QOC Coordinator	October 2014	Established; Will continue until November 2015

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Category	Intervention	Barrier	Responsible Party	Date of Implementation	Intervention Status
	If provider has no previous history of interventions, CR will provide education and request provider to sign attestation stating that they understand and will adhere to Magellan’ critical incident reporting protocol.	1,2,3,4	AI/QOC Coordinator	October 2014	Established; Will continue until November 2015
	If provider has a history of previous interventions, corrective action plan that will be monitored by the Regional Network Credentialing Committee.	2,3	AI/QOC Coordinator	October 2014	Discontinued in July 2015; Magellan will monitor plan internally until November 2015
Inpatient Monitoring Interventions	Establish monthly report (based on authorization data) of the number of members served in inpatient acute settings.	1,2,3,4	AI/QOC Coordinator	October 2014	Discontinued in March 2015
	Compare utilization data to the number of adverse incidents reported.	1,2,3,4	AI/QOC Coordinator	October 2014	Discontinued in March 2015
	Identify providers that have served over 25 members and have not reported a critical incident.	1,2,3,4	AI/QOC Coordinator	October 2014	Discontinued in March 2015
	Provide education to hospitals with 25 members and no reporting history and request provider to sign attestation stating that they understand and will adhere to Magellan’ critical incident reporting protocol.	1,2,3,4	AI/QOC Coordinator	October 2014	Discontinued in March 2015
	Track and trend data to see if providers who were not reporting initiated report submissions using the above protocol.	2,3	AI/QOC Coordinator	January 2014	Discontinued in July 2015; Grievances and Quality of Care Interventions Replaced this intervention to monitor providers.
	If improvements are not identified (e.g., no critical incidents are received in one month), then an individual provider training will be conducted to review the provider’s policies and procedures for tracking and reporting adverse incidents. This intervention, includes: 1. Meeting with risk manager 2. Reviewing aggregate critical incident data for the facility 3. Review current utilization data	2,3	AI/QOC Coordinator	January 2014	Discontinued in July 2015; Grievances and Quality of Care Interventions Replaced this intervention to monitor providers.

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	<p>4. Identify if there are barriers to reporting</p> <p>5. If a low number of aggregate incidents for the total population served are identified, Magellan will reinforce reporting procedure and get signatures to validate training took place.</p> <p>6. If high number of aggregate incidents for the total population served is identified, Magellan the provider will be placed on corrective action plan requiring them to respond on how they will improve reporting.</p>				
	Track and trend data to see if providers who were not reporting initiated report submissions using the above protocol.	2,3	AI/QOC Coordinator	February 2014	Discontinued in July 2015; Grievances and Quality of Care Interventions Replaced this intervention to monitor providers.
	(For those providers not on corrective action plan): if improvement is not indicated once onsite audit is completed, the provider will be placed on corrective action plan that will be monitored by the Regional Network Credentialing Committee.	2,3	AI/QOC Coordinator	December 2014/ January 2015	Discontinued in July 2015; Grievances and Quality of Care Interventions Replaced this intervention to monitor providers.
	If provider is not responsive to Corrective Action Plan (CAP), the RNCC will determine next steps (e.g., placing provider on hold from accepting new members, termination) based on review of actions.	2,3	CMO	January 2015	Discontinued in July 2015; Grievances and Quality of Care Interventions Replaced this intervention to monitor providers.
Enhanced Reporting	Magellan submits a monthly report to DHH of restraints and seclusions by provider. Magellan tracks and trends providers to identify if significant overutilization of restraints or seclusions is identified. If overutilization is indicated (significant increase use of restraints and seclusions), then Magellan will provide action steps taken by provider to address.	N/A	AI/QOC Coordinator	March 2015	Established; Will continue until November 2015

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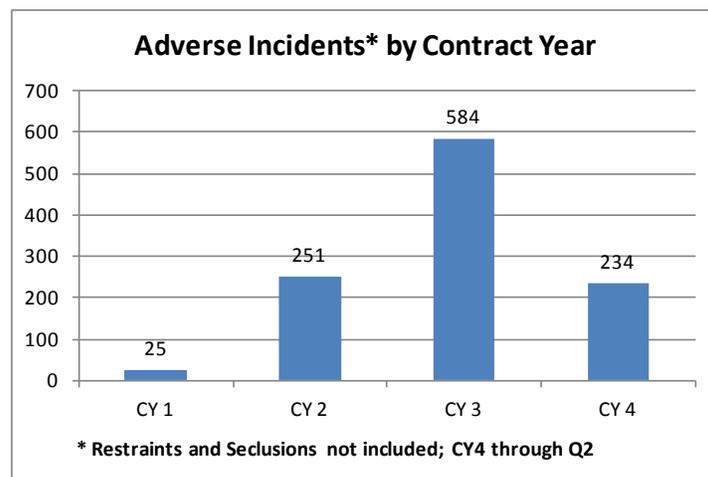
Category	Intervention	Barrier	Responsible Party	Date of Implementation	Intervention Status
	Magellan submits a monthly report to DHH on members that meets or exceeds a threshold of 3 or more elopements per month. Magellan also reports if a provider meets or exceeds total of five or more elopements per month. Report includes name of provider, number of elopements, and action steps taken by provider to address.	N/A	AI/QOC Coordinator	March 2015	Established; Will continue until November 2015
	Magellan submits a detailed monthly report to DHH for incidents of deaths, serious incidents, and abuse. The report identifies action steps taken to address and the status of the incident. This will only include details on investigations conducted by the provider and/or Magellan for abuse reports.	N/A	AI/QOC Coordinator	March 2015	Established; Will continue until November 2015
	Magellan submits a report if a provider meets a threshold of more than 2 reports of death or suicide during a three month period. Magellan will include any provider specific action plans implemented to address.	N/A	AI/QOC Coordinator	March 2015	Established; Will continue until November 2015

**Results**

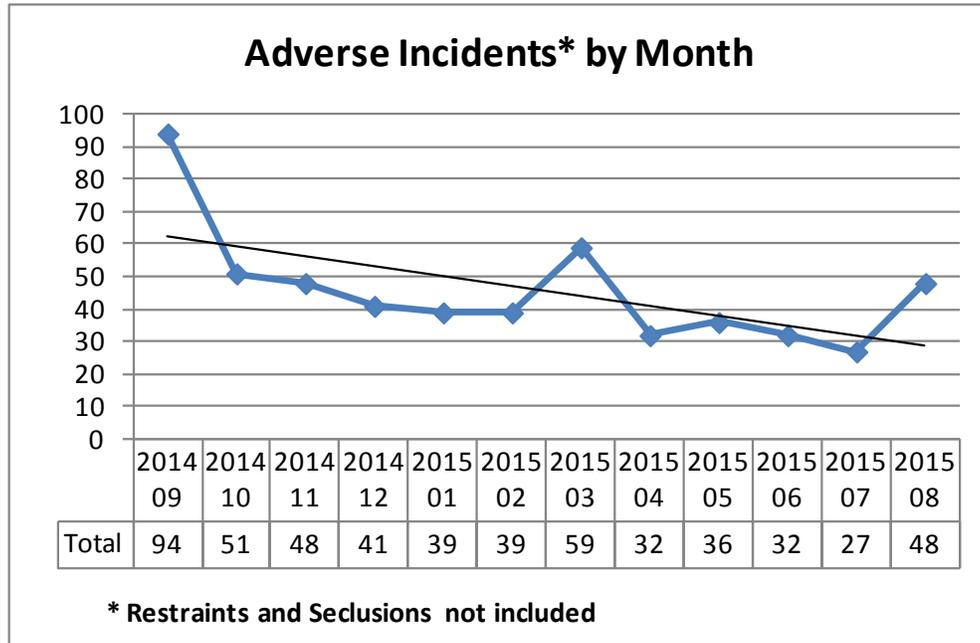
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**Indicator One: Number of Provider Reported Adverse Incidents Reported (excluding Restraints and Seclusions)**

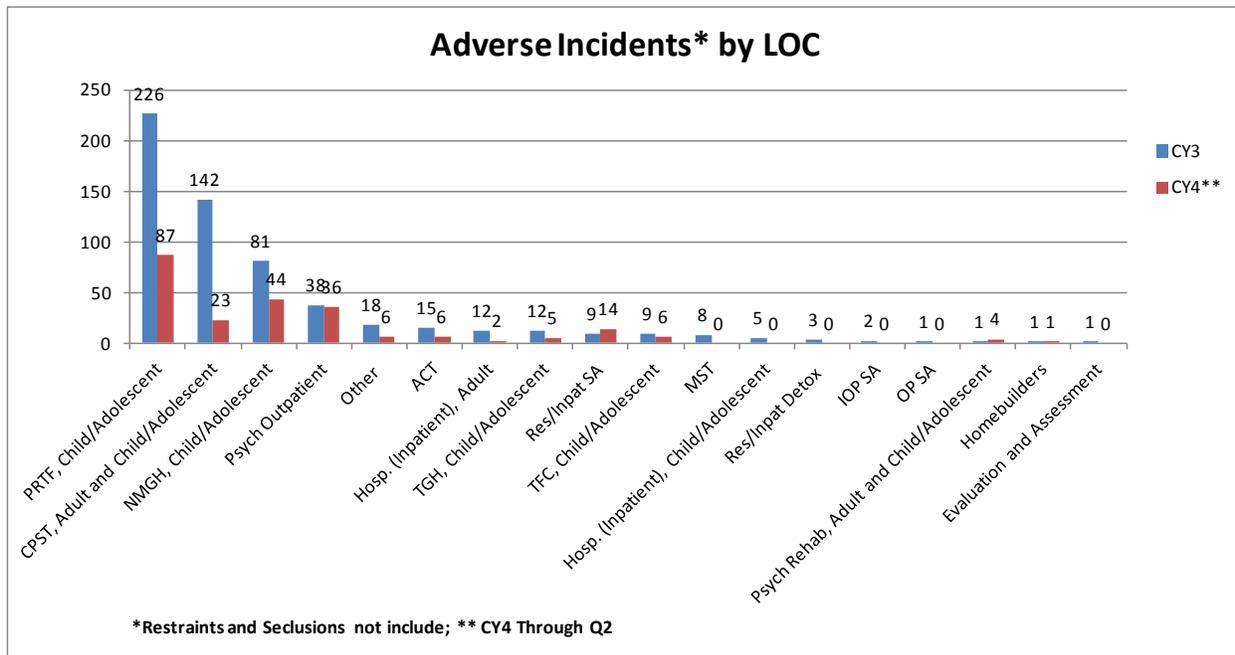
**A. Total number of reports received by all provider**



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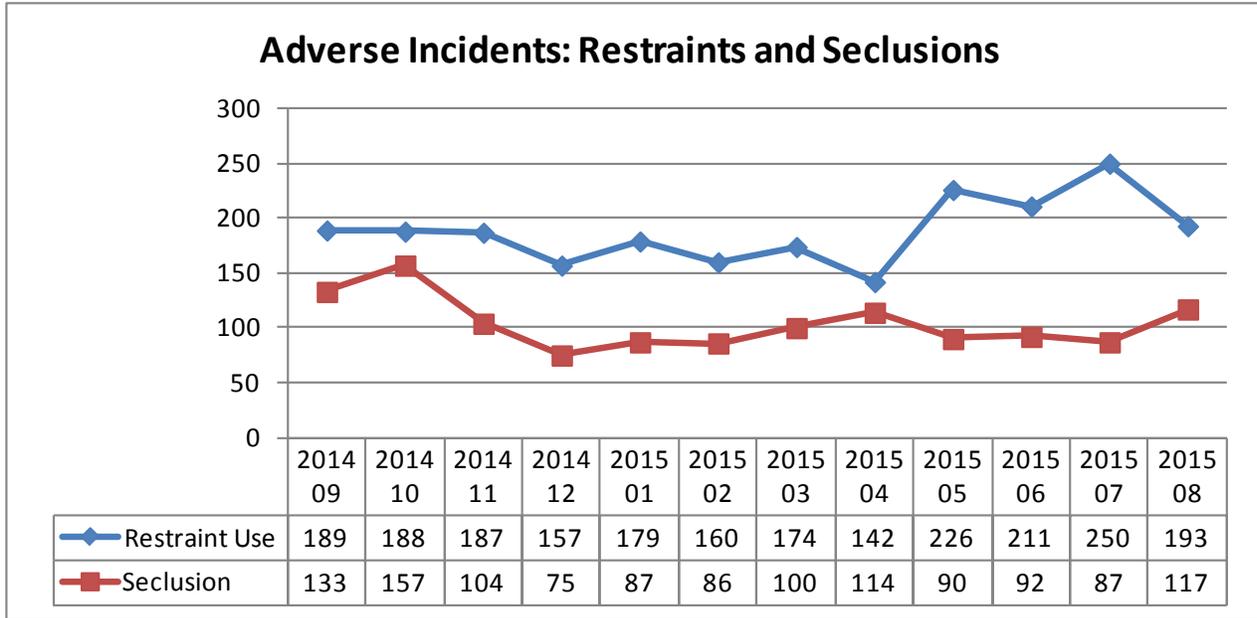
**B. Total number of reports by Level of Care (including Inpatient Providers)**



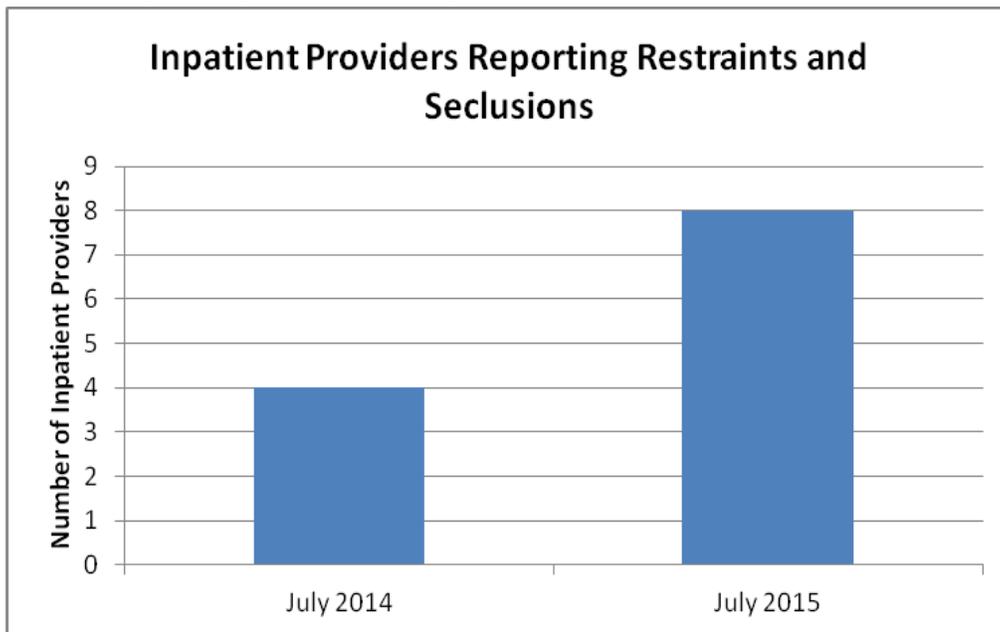
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**Indicator Two: Number of Provider Reported Restraints and Seclusions**

**A. Total number of reports received by all providers**



**B. Total number of inpatient providers who reported.**



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**Indicator Three: Suicide Rate**

**A. The number of suicides and the suicide rate for the Medicaid eligible members and Medicaid members served in Louisiana.**

	Reporting period: January 1, 2015 - August 31, 2015	
	Reported Suicides	Suicide Rate per 100,000
<b>Medicaid Eligible</b>	1	0.085329
<b>Medicaid Served</b>	1	0.936469

**Indicator Four: Homicide Rate**

**A. The number of homicides and homicide rate for the Medicaid eligible members and Medicaid members served in Louisiana.**

	Reporting period: January 1, 2015 - August 31, 2015	
	Reported Homicides	Homicide Rate per 100,000
<b>Medicaid Eligible</b>	0	0.00
<b>Medicaid Served</b>	0	0.00

**Discussion**

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**1. Discussion of Results**

Since only the first two quarters of contract year four are being reported, alternative time ranges were used in the analysis of the results below. The time ranges being analyzed are: 9/1/2013 to 8/31/2014 (*first period*) and 9/1/2014 to 8/31/2015 (*second period*). The number of adverse incidents reported during the first period (376 reports), compared to the second period (532 reports), increased by 156 during the second period, which was a 41.49% increase. The average number adverse incidents reported increased by 13 reports per month during the second period when compared to the first period. Magellan utilized paired t-test to analyze statistical significance of change for the first period compared to the second period and  $p = 0.0346$ . This represents a statistically significant improvement in the number of adverse incidents reported in the second period when compared to the first period.

The top three LOCs (i.e., PRTF, NMGH, and Psych Outpatient) accounted for 71.37% of the reported Adverse Incidents in the first two quarters of contract year four. This does not include restraints and

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seclusions. There were a total of 17 reports for the inpatient level of care in contract year three. Although contract year four only represents two quarters of data, there were only two incidents reported by inpatient providers. There has been an increase in the number of inpatient providers reporting restraints and seclusions. Prior to implementation of PIP, there were only four inpatient providers reporting. A comparison of the number of inpatient providers reporting restraints and seclusions in July 2014 (Q2 of CY3) and the number of inpatient providers reporting restraints and seclusions in July 2015 (Q2 of CY4) doubled to eight providers. Accordingly, the total number of restraints has increased.

The overall age-adjusted suicide rate in the United States was 12.6 per 100,000 in 2012. In the first three quarters of calendar year 2015, the rate of suicide for the Medicaid eligible population for Louisiana was 0.09 per 100,000 and the rate of suicide for the members served was 0.94 per 100,000. These are both below the CDC overall age-adjusted rates for the United States.

The overall age-adjusted homicide rate in the United States was 5.2 per 100,000 in 2013. In the first three quarters of calendar year 2015, the rate of homicide for the Medicaid eligible population for Louisiana was 0.00 per 100,000 and the rate of homicide for the members served was 0.00 per 100,000. These are both below the CDC overall age-adjusted rates for the United States.

*Resource: <http://www.cdc.gov>*

## **2. Limitations**

A limitation of the project is that reporting is dependent on providers following reporting procedures and validation activities are limited. Validation activities of reporting can only be conducted through record reviews or as part of care management. This limits the number of members that Magellan can monitor to determine if reports are being submitted as required.

The report only represents two quarters of data due to the shortened contract period ending November 30, 2015. This should be considered when comparing contract year four data to previous reports.

## **Next Steps**

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### **1. Lessons Learned**

Although successes were realized through this PIP, one of the largest barriers to provider reporting continues to be provider frustration about having to report to multiple entities. With the

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integration of behavioral health into the MCOs, Magellan anticipates a continuation of this barrier especially due to the complexities of having to report to five separate health plans. This is a barrier that will require continued attention in order to improve incident reporting for the Medicaid population.

**2. System-level Changes Made and/or Planned**

Magellan will continue to work closely with providers regarding incident reporting. As the PIHP for Coordinated System of Care population, Magellan will focus efforts to increase provider trainings and monitoring as part of the care management process to ensure that incident reporting continues following the transition.

**VI. Care Management Initiatives**

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

The Care Management/ Utilization Management Program is organized to support the unique needs of members and their families through functional teams reporting to the Care Management/Utilization Review Administrator who oversees the department and also serves as the Chief Clinical Officer. The CM/UM functions are performed by CM/UM teams that include a Clinical Manager, Team Leaders, Care Managers, Care Workers and Peer Recovery Navigators or Follow-up Specialists. Functional teams also include children and adult subject matter experts. Care Managers within each team are highly experienced and specialized in providing services to the special populations served by each team. For example, the adult CM/UM team includes clinicians with experience working with pregnant women with behavioral health needs, women with SUD substance using and have young children, persons with HIV, and IV drug users. Similarly, Care Managers serving the child/youth population have expertise working with children with behavioral health needs in contact with child serving systems but not functionally eligible for CSoc and youth in transition. All teams include clinicians with expertise in

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addressing the needs of members who are experiencing substance use disorders, involved with State agencies, and members with complex clinical needs.

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

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

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**Assertive Community Treatment Scorecard**

Magellan has established benchmarks for performance in Louisiana to meet national standards for pay for performance and for system transformation. The Louisiana Unit created a scorecard for Assertive Community Treatment providers with a set of performance measures balancing services, fidelity, and outcomes, with the ACT scorecard already tied to a pay-for-performance model. The ACT Scorecard has measures of service (average encounters per member and members with more than six services), fidelity (DACTS), and outcomes (inpatient mental health admissions and rate and emergency room visits for substance use or mental health). Thresholds for “green” and “yellow” for each measure were created by an analysis of historical provider data, utilization data from other Magellan public sector sites that also offer this service, and Medicaid national averages. A total score is calculated for a biannual adjustment in the rate for pay for performance. Quarterly scorecards are disseminated as well to assist providers in tracking interim progress. The picture below provides the final scorecard disseminated in November 2015.

Average Number of Encounters Per Member By Agency					Percentage of Members Having 6 or More Services				
	Less than 6 Encounters	6-13 Encounters	14 or more Encounters		Less than 75%	75% - 99%	90% or Higher		
	Previous	Q2 2015	Progress		Previous	Q2 2015	Progress		
CBS	5.32	5.09	↓ -0.23	CBS	46.4%	42.0%	↓ -4.4%		
FPS Met	3.32	3.55	↑ 0.23	FPS Met	13.8%	23.4%	↑ 9.6%		
FPS Slid	4.12	4.01	↓ -0.11	FPS Slid	26.8%	37.6%	↑ 10.8%		
NHS Alex	7.29	8.85	↑ 1.56	NHS Alex	71.2%	79.8%	↑ 8.7%		
NHS BR	7.36	7.61	↑ 0.25	NHS BR	71.3%	75.2%	↑ 3.9%		
NHS LAF	7.53	9.09	↑ 1.56	NHS LAF	71.8%	76.6%	↑ 4.8%		
NHS LC	7.20	8.38	↑ 1.18	NHS LC	74.2%	77.4%	↑ 3.2%		
NHS NOLA	7.65	8.89	↑ 1.24	NHS NOLA	72.9%	79.9%	↑ 7.0%		
NHS Shrev	8.08	7.49	↓ -0.59	NHS Shrev	82.5%	77.5%	↓ -5.0%		
RHD NOLA	5.27	6.03	↑ 0.76	RHD NOLA	51.5%	60.7%	↑ 9.1%		
RHD ACT	5.94	5.91	↓ -0.03	RHD ACT	65.5%	65.3%	↓ -0.3%		
VoA	7.20	7.00	↓ -0.20	VoA	74.0%	69.1%	↓ -5.0%		

IP Psych Hosp. Admits per 100 ACT Recipients					IP Psych Hosp Readmit Rate				
	Greater than 16 Adm	16 - 5 Admits	Less than 5 Admits		Greater than 15%	15% - 5%	Less than 5%		
	Previous	Q2 2015	Progress		Previous	Q2 2015	Progress		
CBS	9.58	8.62	↓ -0.96	CBS	43.5%	40.0%	↓ -3.5%		
FPS Met	1.74	2.42	↑ 0.68	FPS Met	20.0%	20.0%	↔ 0.0%		
FPS Slid	2.70	8.13	↑ 5.43	FPS Slid	0.0%	40.0%	↑ 40.0%		
NHS Alex	7.47	7.17	↓ -0.30	NHS Alex	23.1%	17.7%	↓ -5.4%		
NHS BR	6.48	3.90	↓ -2.58	NHS BR	28.6%	15.4%	↓ -13.2%		
NHS LAF	10.49	9.40	↓ -1.09	NHS LAF	43.3%	45.2%	↑ 1.9%		
NHS LC	3.68	2.74	↓ -0.94	NHS LC	0.0%	0.0%	↔ 0.0%		
NHS NOLA	5.85	7.11	↑ 1.26	NHS NOLA	30.0%	40.0%	↑ 10.0%		
NHS Shrev	5.82	6.11	↑ 0.29	NHS Shrev	29.6%	13.6%	↓ -16.0%		
RHD NOLA	6.82	8.78	↑ 1.96	RHD NOLA	31.0%	30.8%	↓ -0.2%		
RHD ACT	3.17	3.27	↑ 0.10	RHD ACT	26.3%	20.0%	↓ -6.3%		
VoA	3.57	10.67	↑ 7.10	VoA	12.5%	31.3%	↑ 18.8%		

ACT Program Fidelity (DACTS) Score					Average Length of Stay**				
	Less than 112	112 - 134	Greater than 135		Greater than 10	7 - 10	Less than 7		
	CV2	CV3	Progress		Previous	Q2 2015	Progress		
CBS	116.00	118.00	↑ 2.00	CBS	4.59	3.53	↓ -1.06		
FPS Met	116.00	121.00	↑ 5.00	FPS Met	5.20	5.00	↓ -0.20		
FPS Slid	N/A	121.00	N/A	FPS Slid	5.25	5.00	↓ -0.25		
NHS Alex	114.00	117.00	↑ 3.00	NHS Alex	6.88	7.12	↑ 0.24		
NHS BR	111.00	120.00	↑ 9.00	NHS BR	6.46	7.62	↑ 1.16		
NHS LAF	119.00	126.00	↑ 7.00	NHS LAF	6.49	5.22	↓ -1.27		
NHS LC	114.00	123.00	↑ 9.00	NHS LC	6.17	3.60	↓ -2.57		
NHS NOLA	121.50	129.00	↑ 7.50	NHS NOLA	5.70	6.69	↑ 0.99		
NHS Shrev	119.00	123.00	↑ 4.00	NHS Shrev	4.16	4.84	↑ 0.68		
RHD NOLA	117.00	119.50	↑ 2.50	RHD NOLA	6.02	5.85	↓ -0.17		
RHD ACT	121.50	124.00	↑ 2.50	RHD ACT	4.83	5.93	↑ 1.10		
VoA	107.00	121.00	↑ 14.00	VoA	4.43	8.21	↑ 3.78		

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**VII. Recovery and Resiliency Care Management**

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

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

- Member with two (2) or more admissions to an acute inpatient or residential level of care within 60 days with a diagnosis of Schizophrenia, Bipolar Disorder or Major Depression.
- Children ages 12 and under who are hospitalized.
- Pregnant women who use substances.
- Members ages 21 and under who are discharged from a state psychiatric inpatient program followed by one or more admission/hospitalization.
- Members who use IV drugs.
- Members with one or more admission for an eating disorder.
- Members who have chronic or severe physical health and mental health co-morbid conditions.
- Members identified as high risk based on predictive modeling results.
- Members identified by treatment planners, such as WAAs, Local Governance Entities (LGEs), or other providers as needing Intensive Case Management.

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

- The RCM Care Managers were assigned to work with the five Bayou Health plans to ensure appropriate coordination of care for physical and behavioral health need.
- The RCM Care Managers actively participate in the state's Birth Outcome Initiative program by connecting substance using expectant mothers to the appropriate services.
- RCM Care Managers complete crisis safety plans for all members enrolled in RCM and attach the plan to each member's file through the Magellan system.

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- RCM provides education to emergency departments and providers about the existence and role of the RCM program.

**VIII. Evaluation of Over/Under Utilization of Services**

One of the pillars of Magellan is to ensure members receive services that are individualized, effective, provided in the least restrictive setting and medically necessary. In order to accomplish this goal, it is imperative that members receive services at the appropriate level of care while not over or under utilizing services in other levels of care. The Utilization Management Committee (UMC) monitors quality indicators to identify potential over and under-utilization of services. When an aberrant pattern or trend is identified, the UMC conducts a root cause analysis and recommends interventions to the QIC. This information allows the QIC to quickly identify where to focus improvement efforts.

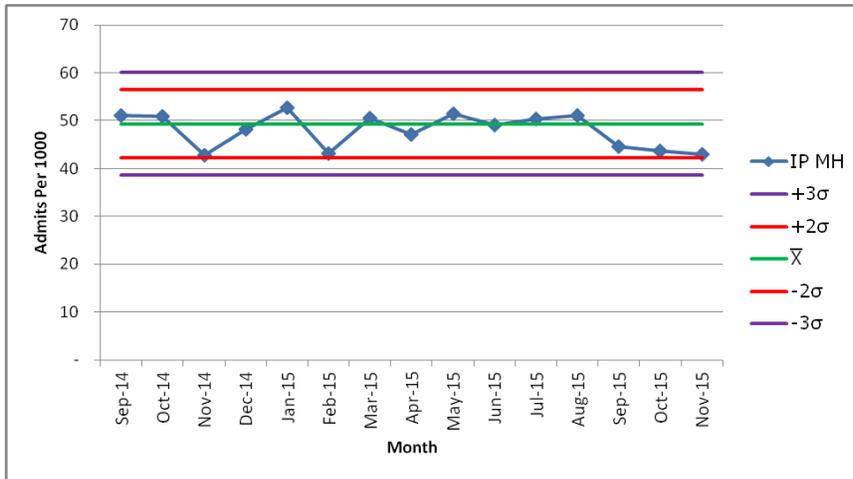
An overview of utilization management metrics that are evaluated by the UMC are provided in this section. They include:

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

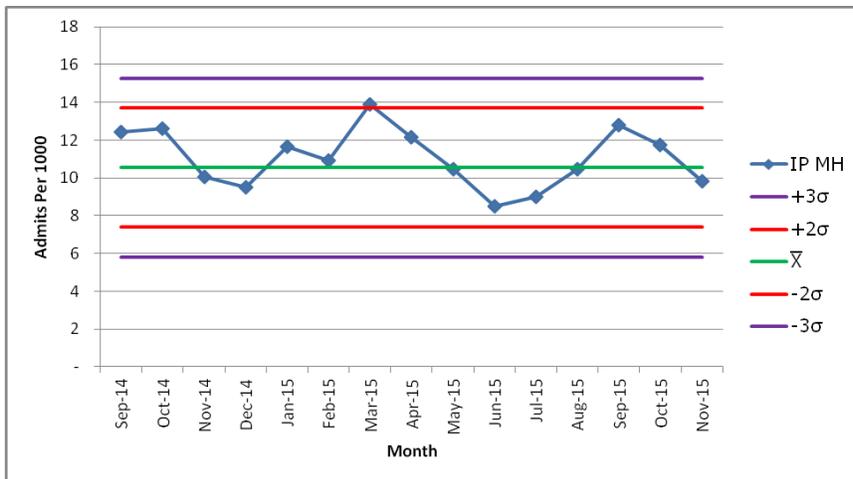
The UMC utilizes control charts to evaluate utilization trends based on standard deviations from the mean to identify statistical over or under utilization detected. When evaluating the metrics, it is important to consider that trends become more stable as the data mature. Opportunities for improvement are indicated when over/under utilization or utilization above or below two standard deviations from the mean, are detected over a period of time. Control charts use data from December 1, 2013 to November 30, 2015. Means represent data from 09/01/2014 – 11/30/2015. Graphs below represent data from 09/01/2014 – 11/30/2015.

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**IP MH Admissions per Thousand**  
**Adult**



**Child**

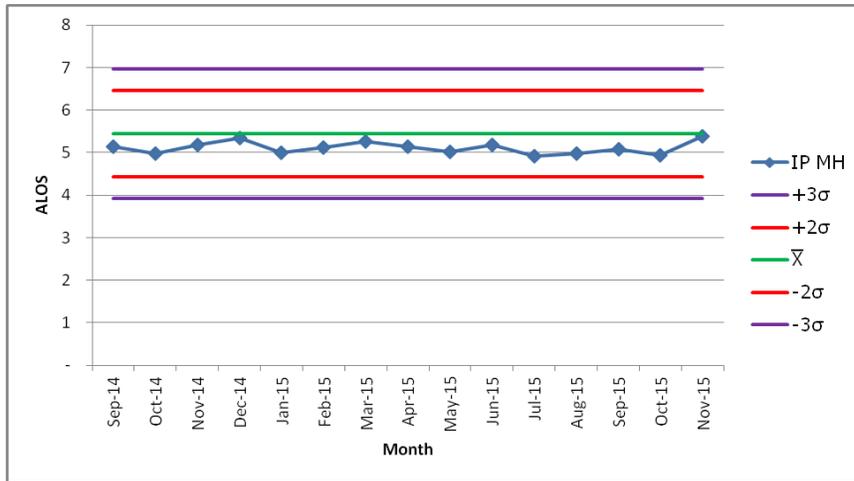


The adult inpatient mental health admissions dropped slightly for the time period between 09/01/2014– 11/30/2015, and child inpatient mental health admissions per thousand metrics held steady with only a very slight increase during this period. The mean number of inpatient admissions per thousand is 49.3 for adults and 10.5 for children. Both adult and child admissions showed variability around the mean remaining around two standard deviations. Child admission trends are consistent with impacts of seasonality (e.g., lower admissions in summer months due to children not being in school, increases in admissions when school starts, etc.).

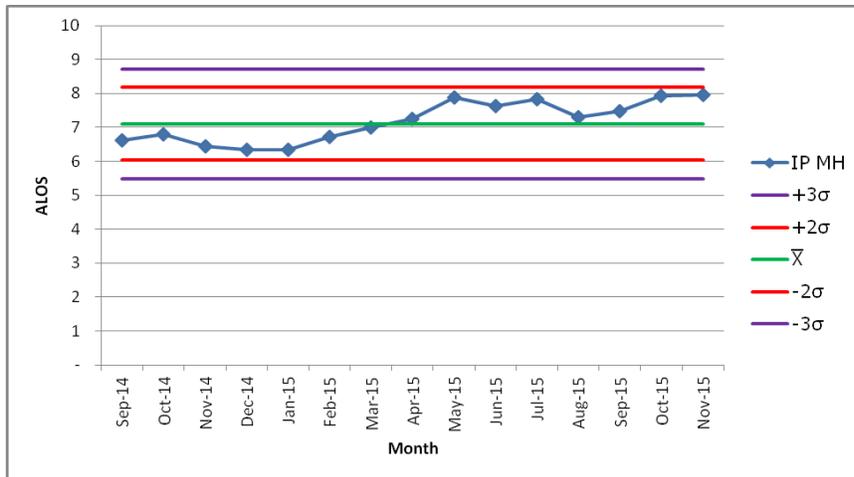
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**IP MH ALOS**

**Adult**



**Child**

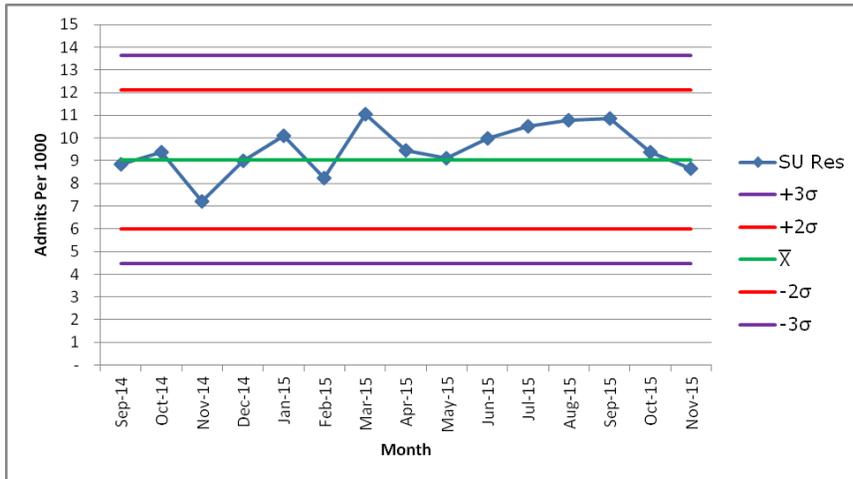


The adult inpatient mental health ALOS metrics showed an overall downward trend. The mean ALOS for IP MH for adults was 5.4 days. ALOS for adults trended below the mean for 09/01/2014 – 11/30/2015. This can be attributed to the continuing efforts of the Utilization Management department. There has been significant shaping at this level of care to ensure members are able to discharge to the appropriate lower level of care when medical necessity criteria for IP are not met. The Child IP ALOS mean was 7.1 days. Children ALOS showed a positive trend line but remained within two standard deviations from the mean.

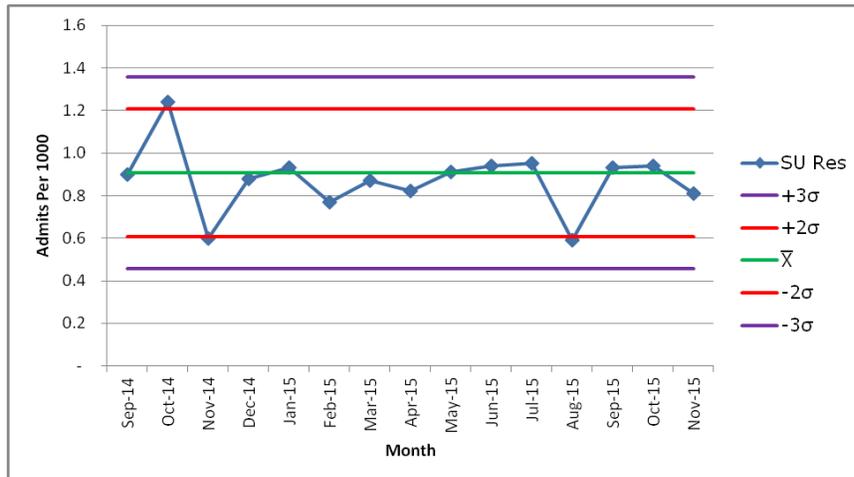
**SU Residential Admissions per Thousand**

**Adult**

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**Child**

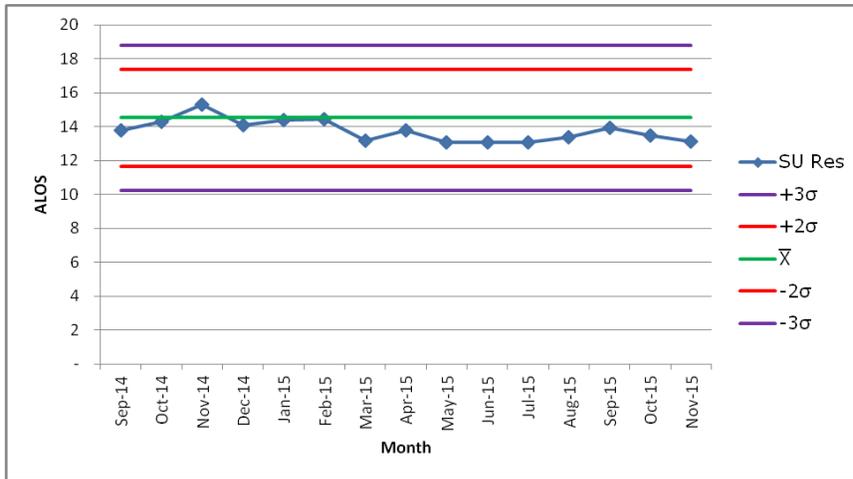


The adult substance use residential admissions per thousand metrics show an overall upward trend while the child substance use residential admissions overall held steady. During this time period, the mean number of admissions per thousand for Adult Substance Use (SU) Residential was 9.02, significantly higher than contract year three mean of 3.4. The mean for Child SU residential was 0.91, which was nearly identical to the mean of 0.92 in contract year three. Because of the low numbers represented in these metrics, small shifts can appear to be significant. Both adult and child admissions showed variability around the mean remaining around two standard deviations.

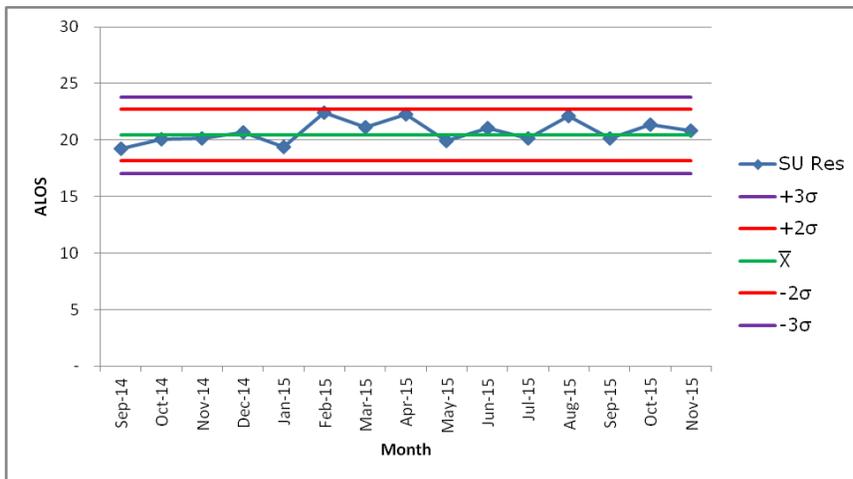
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**SU Residential ALOS**

**Adult**



**Child**



The mean ALOS for adult residential substance use was 14.5 days. The child ALOS was 20.4 days. The data is trended below the mean for adults and around the mean, both above and below, for children with neither population showing more than one standard deviation from the mean. Magellan Care Managers continue to actively work with providers to promote individualized treatment models rather than traditional programmatic model (e.g., 28 days) to individualized treatment models.

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

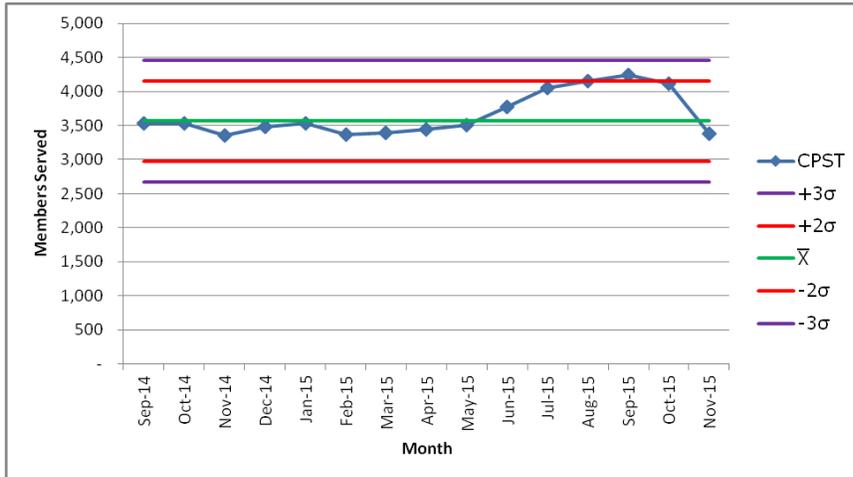
Graphs for adult CPST, PSR, ACT, Substance Use IOP and other outpatient services are provided below. Members served data for all metrics generally trended at or above the mean, which is consistent with the goals of the UM program. The decrease in both the members served and the ANOU of the ‘other outpatient services’ category is believed to be attributed to increases in the HCBS, which have sustained

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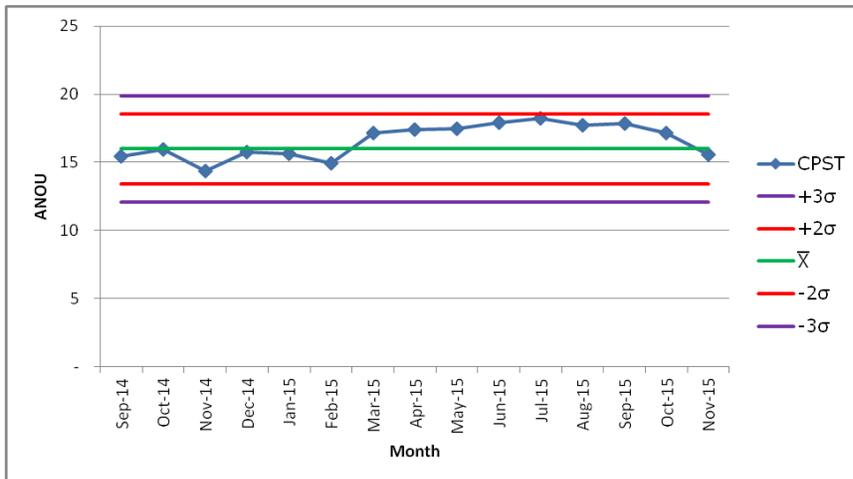
numbers due to the Independent Assessment process that has increased enrollment in 1915(i) Waiver and services such as CPST/PSR and ACT.

**Adult CPST**

**Member Served**



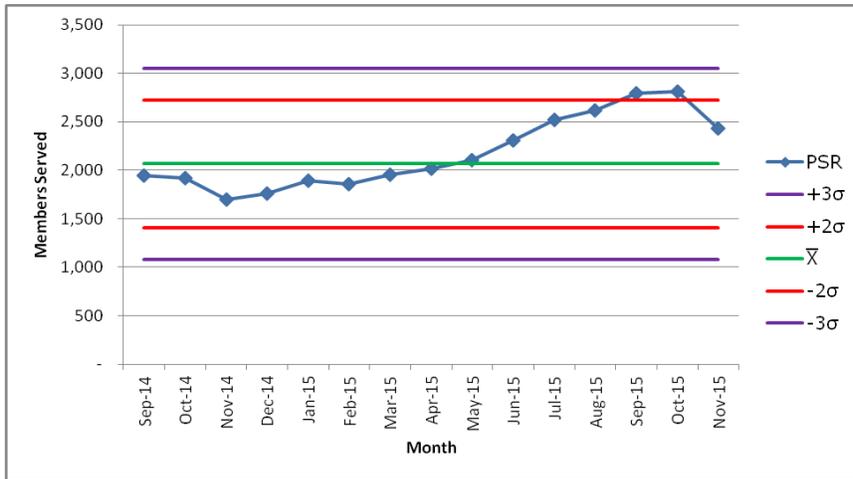
**ANOU**



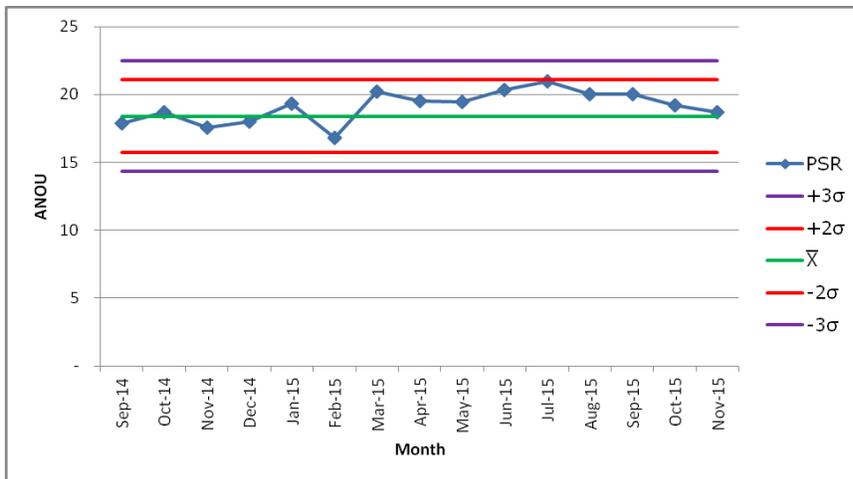
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**Adult PSR**

**Member Served**

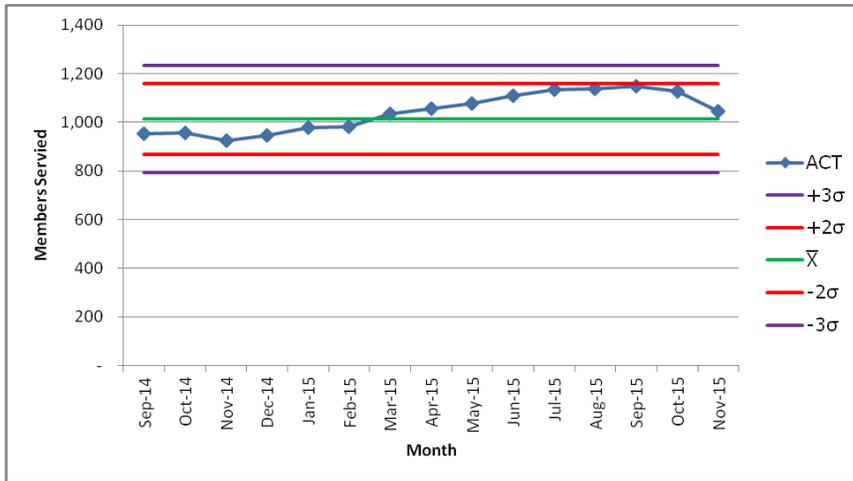


**ANOU**

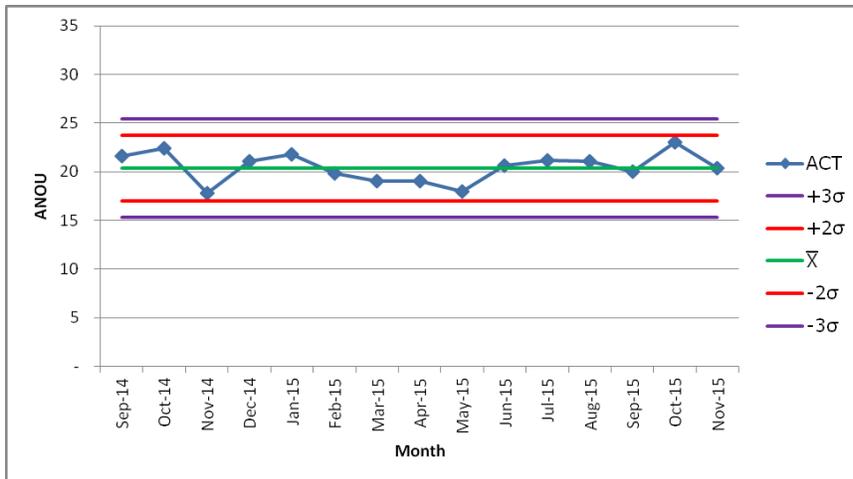


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**Adult ACT**  
**Member Served**



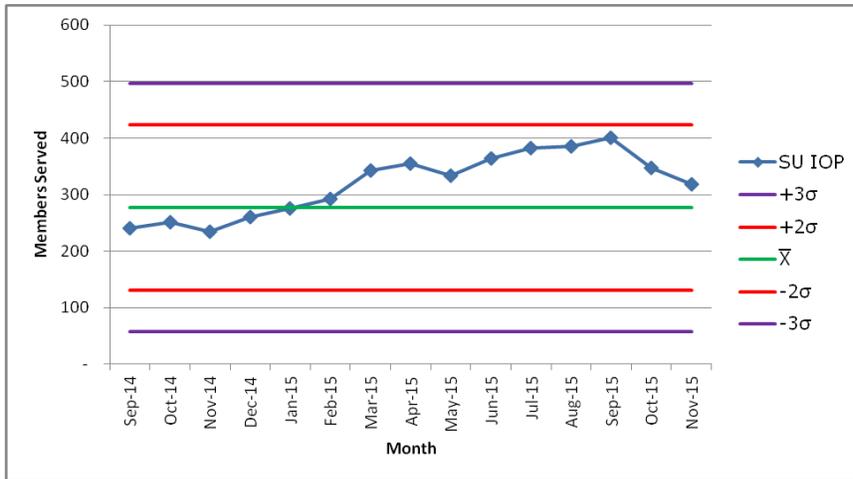
**ANOU**



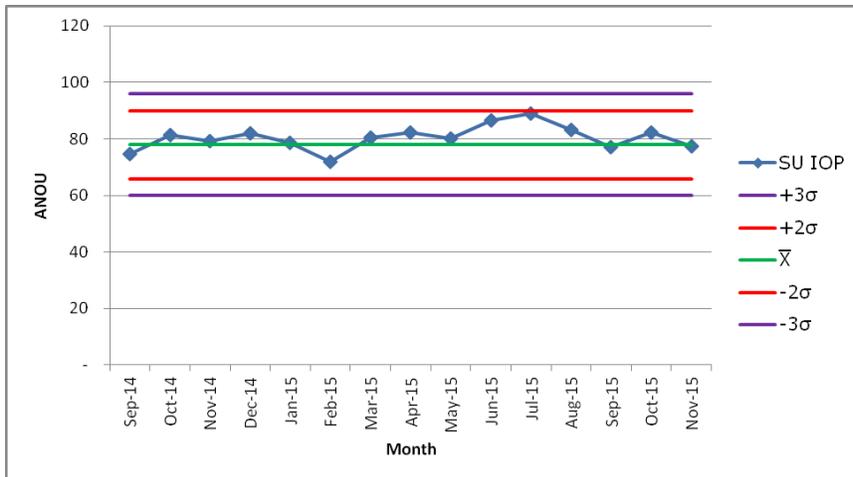
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**Adult Substance Use IOP**

**Member Served**

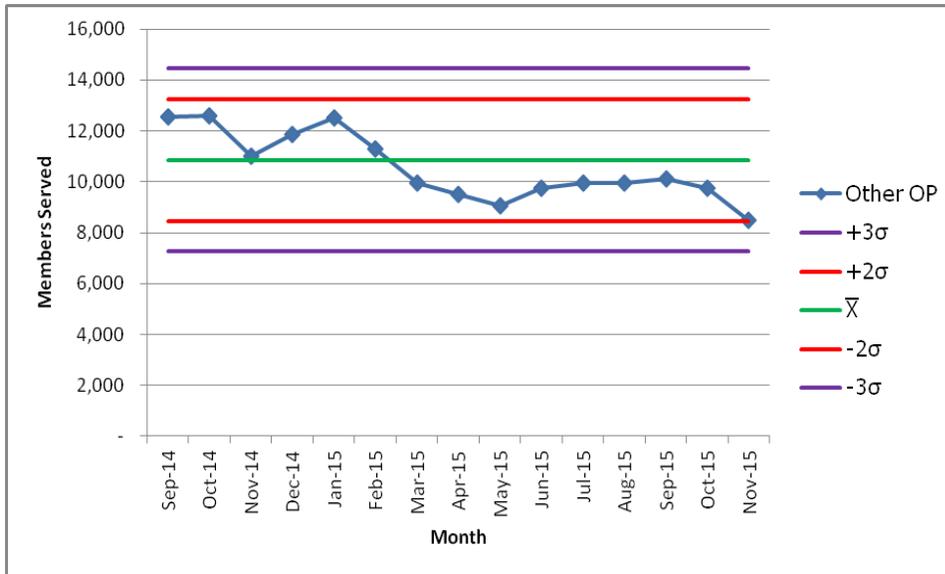


**ANOU**

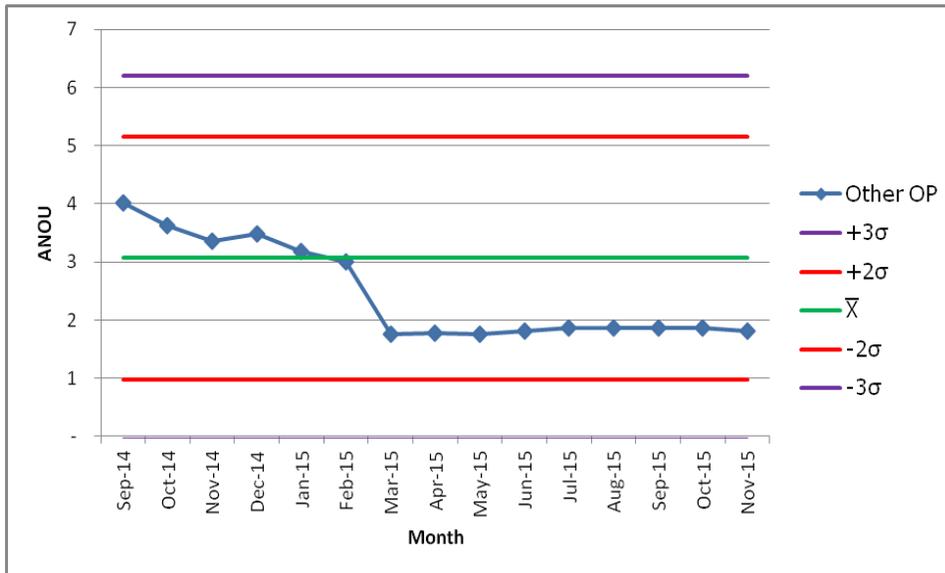


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**Other Outpatient Services**  
**Member Served**



**ANOU**



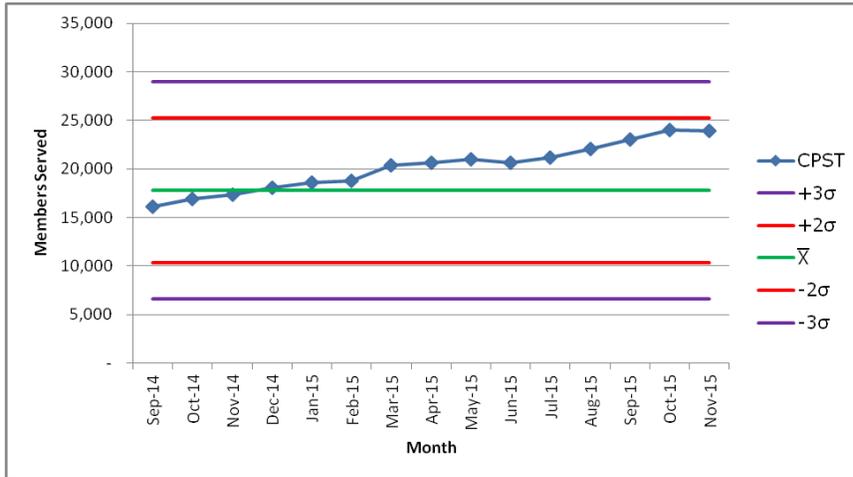
**Child Outpatient Average Number of Units (ANOU) and Members Served**

Graphs for child CPST, PSR, Substance Use IOP and other outpatient services are provided below. Members served data for all metrics are trending above the mean with most trending positively. There was a significant increase in child members served by Home and Community Based services. Utilization for CPST increased 48.3% and PSR increased 49.0% from September 2014 – November 2015. This

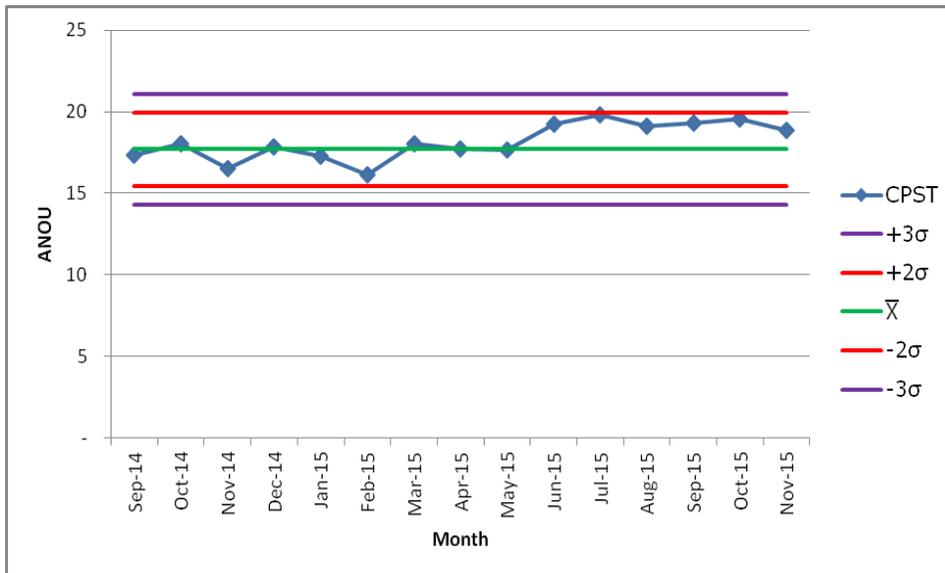
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indicates that more members are accessing services than in previous contract years. ANOU showed variation near the mean for most outpatient levels of care.

**Child CPST**  
**Member Served**



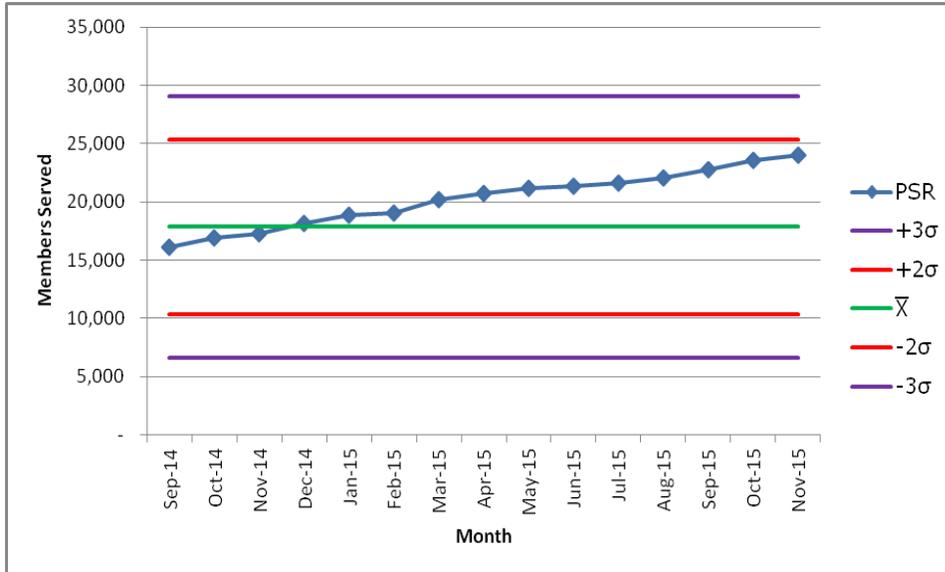
**ANOU**



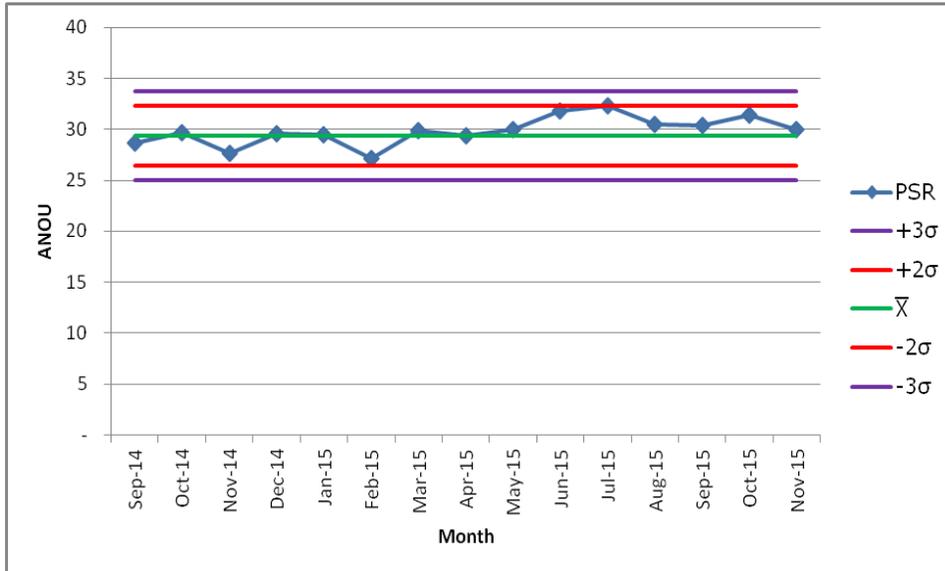
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**Child PSR**

**Member Served**

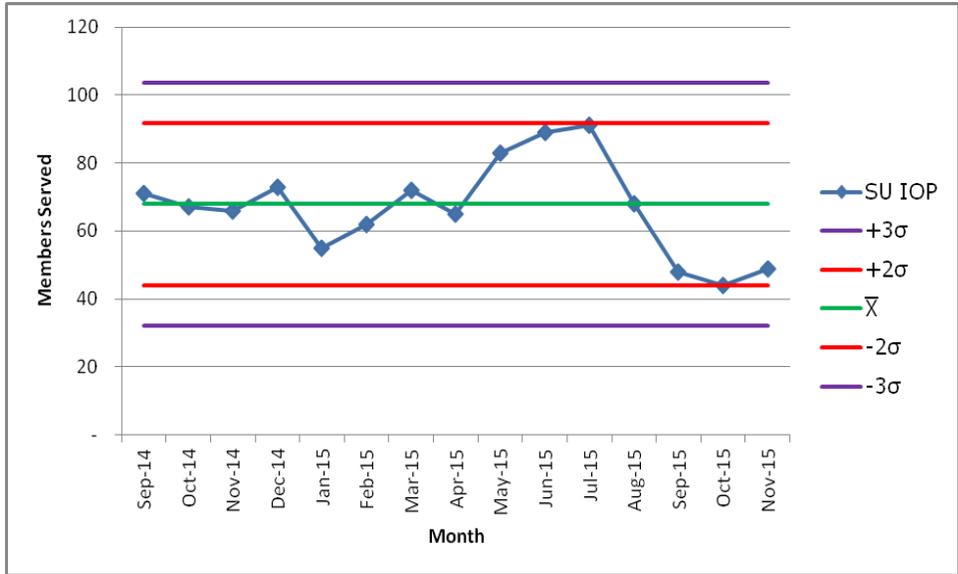


**ANOU**

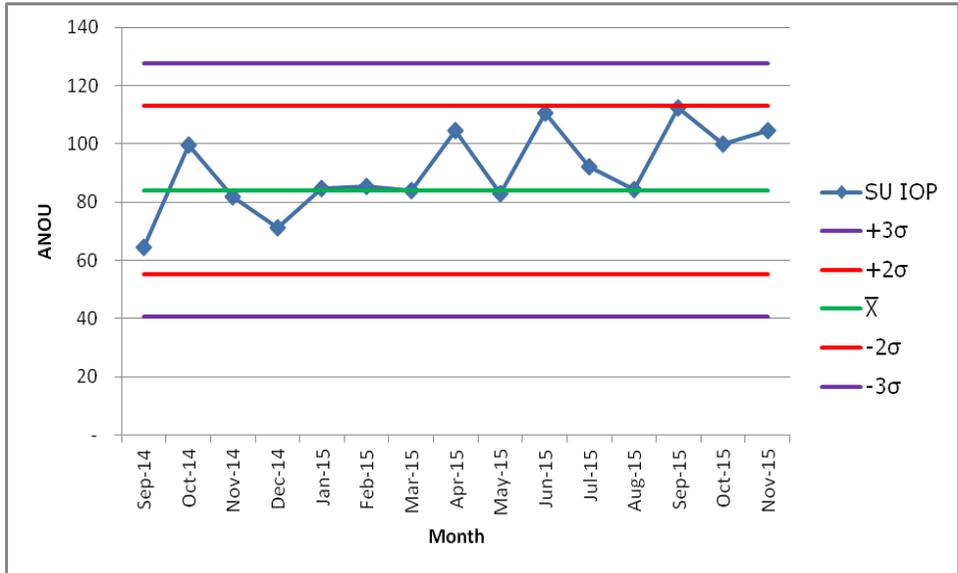


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**Child Substance Use IOP**  
**Member Served**



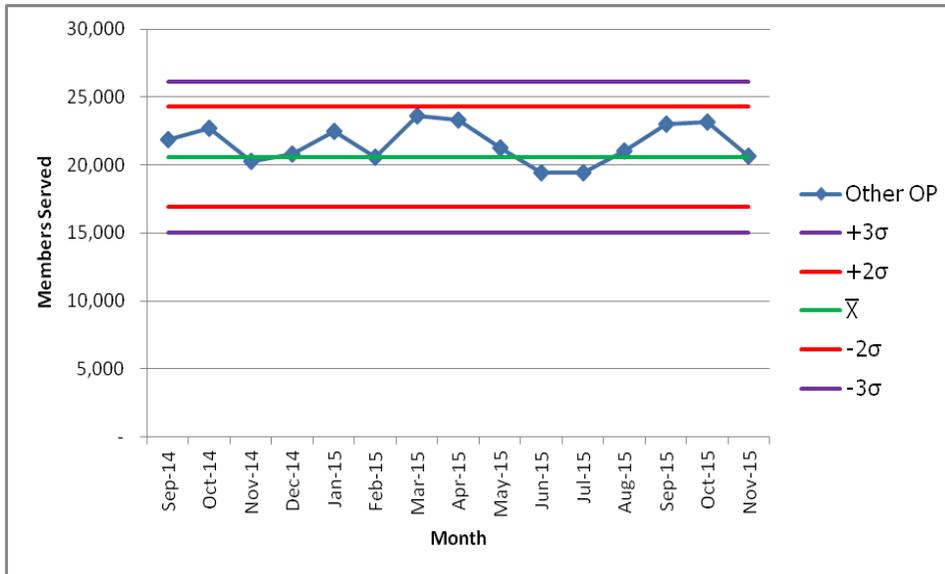
**ANOU**



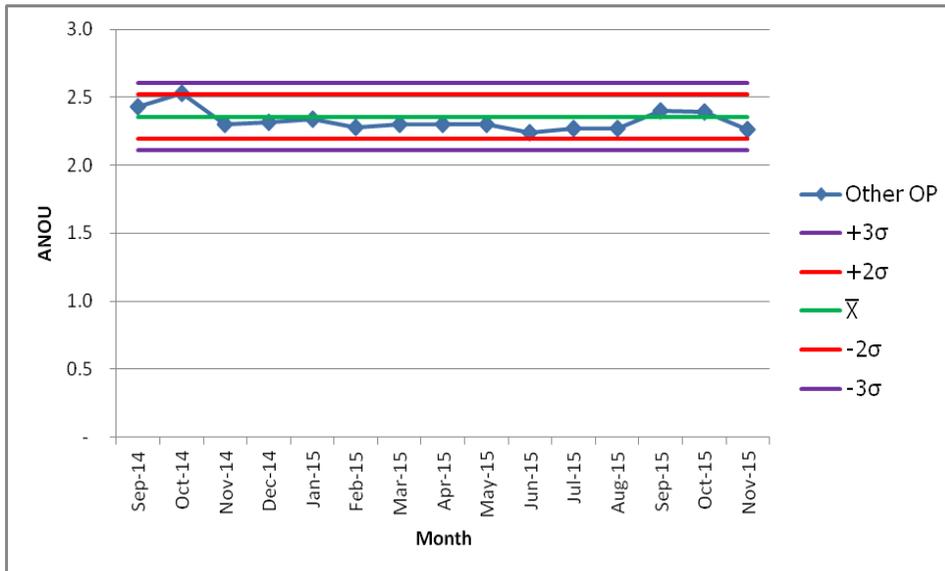
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**Other Outpatient Services**

**Member Served**



**ANOU**



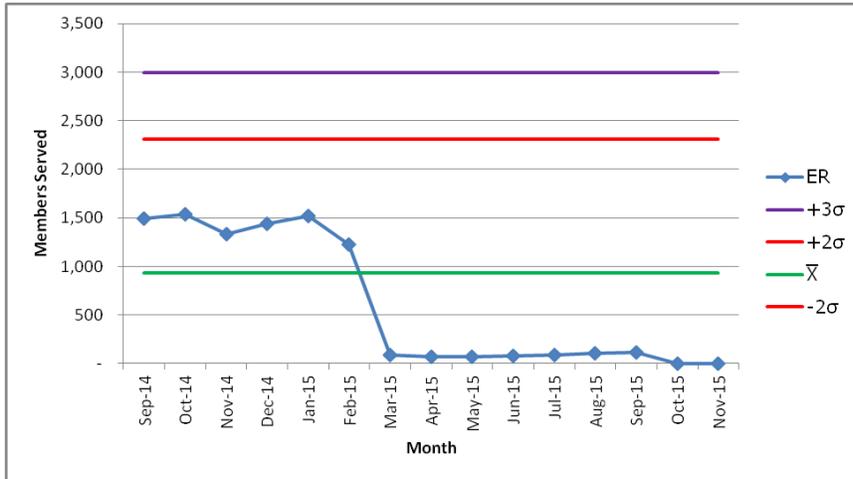
**Emergency Room Utilization**

Emergency room utilization dropped significantly for both the adult and child populations. The adult and child utilization remained above or at the mean for the initial seven months and then dropped to nearly two standard deviations below the mean for the last five months. This can be explained due to changes in provider billing practices implemented by Medicaid in March 2015. Providers only billed for

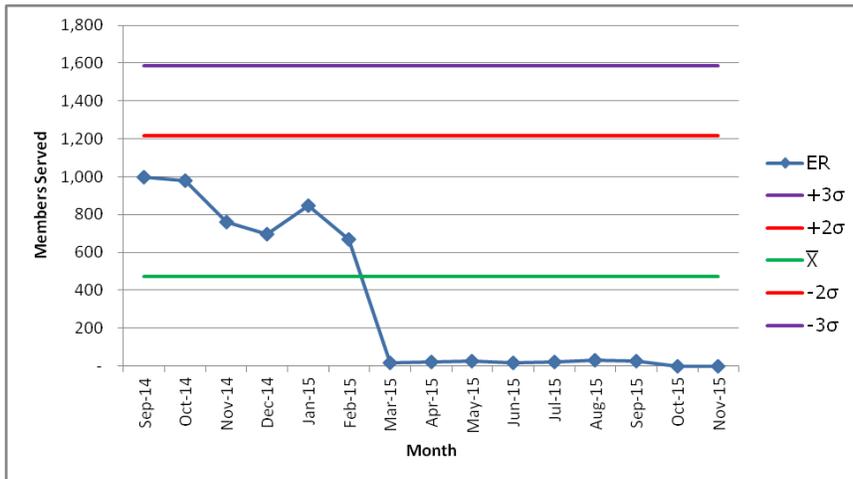
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mental health/substance use (MH/SU) professional fees associated with the admission as compared to billing for all services associated with a MH/SU admission prior to March 2015.

**Adult**



**Child**



**IX. Screening Program Activities**

The Louisiana Unit QI program develops and demonstrates ongoing screening programs to identify members that would benefit from behavioral health services. Magellan utilizes the Child and Adolescent Needs and Strengths Assessment (CANS) Comprehensive screening tool for minor populations to determine eligibility for the CSoC program. The Level of Care Utilization System (LOCUS) is used as part of the 1915(i) State Plan Amendment eligibility determination process for the adult population. If members are determined to be eligible for these programs, they have access to an expanded array of home and community-based services not available to the general Medicaid population.

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

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

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

**X. Behavioral / Medical Integration Activities**

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

Recovery and Resiliency Care Management (RCM) care managers are assigned to work with the five Bayou Health Plans to ensure continuous care is provided to members. The Louisiana Unit care managers, medical administrator, and chief medical officer (CMO) attend rounds with the plans. The CMO is also available for further consultation, when needed. Magellan also has one Recovery and Resiliency care manager assigned to work with pregnant women with behavioral or substance use disorders. This care manager works closely with state-wide OB/GYN professional groups, local health units, hospitals, residential treatment facilities, behavioral health providers and health plans to coordinate care for these members at high risk of negative outcomes. These members are assigned to the highest level of the Tiered Care Management model.

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

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

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

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

Magellan uses data from these multiple sources to promote improvement in integration between the medical and behavioral providers. First, our quality management team reviews for provider collaboration as part of their treatment record reviews. Where a deficiency is noted, the provider is offered additional feedback and training or, in cases of continued problems, is placed on a corrective action plan. Providers are expected to provide the PCP with information about the Member's ongoing needs, especially where a Member is hospitalized or requires complex services. Second, we use our grievance process as a means of identifying issues related to communication with PCPs.

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

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**XI. Coordination of Care Activities**

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

- Enhanced involvement of follow-up specialists with members who are receiving treatment in inpatient settings;
- Bridge on discharge appointments;
- Independent Assessment Community-Based Care Management program to improve coordination of care for the adult SMPI population; and
- Standardized (waiver-compliant) plan of care for children enrolled in CSoC and adults with 1915(i) SPA eligibility.

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

The Follow-Up team was actively involved in improving coordination of care for those members admitted to an inpatient provider via the following interventions:

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

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The Louisiana Unit continued the Bridge on Discharge Program with one high utilization psychiatric inpatient hospital to improve appointment attendance of follow up appointments following discharge from an inpatient setting. The BOD is a step down outpatient service meant to immediately ‘bridge’ gaps between inpatient and ambulatory care and is not a substitute for the community provider of choice. A bridge session is considered part of discharge planning which is begun during inpatient admission with information obtained during inpatient benefit certifications including the insured’s community tenure risk factors. During the inpatient continued stay benefit certification(s) any barriers to community tenure are updated as needed to maintain or re-design the discharge plan. Magellan required that the discharge plan included a provider name with a date and time. In contract year four, the BOD program and follow up team intervention were monitored via the Transitional PIP. Please see **Section V Quality Improvement Activities and Performance Improvement Projects** for details on outcomes.

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

Independent Assessor/Community Based Care Manager (IA/CBCM) provided a similar service for adults with Serious Mental Illness. IA/CBCMs are conflict of interest free practitioners that collaborated with newly eligible for 1915(i) member and treating providers to construct a plan of care to meet the member’s needs, including physical and safety needs.

#### **Coordination of Care with Primary Care Physicians**

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

Magellan network providers are required to ascertain whether the member is being seen by a PCP as part of the assessment and treatment planning process. For members with a clear indication of a physical health issue, such as cardiovascular disease, diabetes, or hypertension, the provider must identify, obtain information on the PCP, and seek the member’s written permission to contact and communicate with the PCP. In such cases, the provider works with the PCP to discuss the treatment plan, medication management, ongoing service needs, and other issues that impact the member’s

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treatment and well-being. As appropriate, compliance with a medical regimen can be incorporated in the member's behavioral health treatment plan. The PCP is included as part of the member's treatment team and works collaboratively with the provider to manage an integrated Plan of Care (POC).

**Ensuring Appropriate Care Coordination with the PCP**

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

- Care Managers review and ensure that such care coordination exists as part of their **utilization management** functions. If a deficiency is identified, they will notify the provider and, as needed, work with the provider to facilitate such communication. Magellan contacts the Bayou Health plan care managers to refer members with medical needs without an identified PCP. Coordination of care with the PCP is an integral part of the services we provide for members with complex needs enrolled in RCM. For these members, we use the joint treatment planning process as one of the primary ways we ensure there is communication and coordination of care between multiple providers and systems of care.
- The quality management team reviews for this type of collaboration as part of our treatment record reviews. Where a deficiency is noted, the provider is offered additional feedback and training or, in cases of continued problems, is placed on a corrective action plan. Providers are also expected to provide the PCP with information about the member's ongoing needs, especially where a member is hospitalized or requires complex services. We use our grievance process as a means of identifying any issues related to communication with PCPs. When we receive a grievance regarding lack of participation between the PCP and BH provider, our quality management or provider network staff reach out to the provider to address the issue. If a trend is noted in the lack of communication, we will implement a focused process to address the issue. There were no grievances regarding PCP coordination in contract year four.

**XII. Clinical/Functional Outcomes Activities**

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

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individuals and geared towards measurement of the NOMs domains, with a strong recovery and resiliency orientation. The primary components of the Louisiana Unit *Outcomes 360* include the LA Child and Adolescent Needs and Strengths (CANS) Comprehensive.

**Child and Adolescent Needs and Strengths Assessment (CANS):**

Magellan has used CANS assessment tools for nearly a decade partnering with providers to understand how best to use the information obtained from the CANS tool for assessment, treatment planning, and measuring outcomes. Magellan created a CANS system integrating training, certification, individual reports, and provider web reports – all available to network providers free of charge. CANS provides state-of-the-art support through the Magellan provider portal, continuing education, qualified on-line training and certification system, learning collaboratives in-person and by webinar, and access to CANS creator, John Lyons, PhD, through a consulting agreement. The Louisiana CSoC CMC utilizes the CANS Comprehensive (2012) version for eligibility and outcomes and is contracted with the Praed Foundation for their Training Collaborative website for on-line CANS comprehensive training capacity. The following section provides an analysis of CANS data showing positive outcomes for the program. The analysis includes 197 CSoC members with a paired initial and discharge CANS submitted electronically from 6/1/15 – 8/31/15. The Global Score, which is a SUM of all items scores, and the Domain Level scores, were used in this analysis. Outcomes included in this report depict three areas: All Children/Youth; Children/Youth with Trauma; and Most Severe Children/Youth.

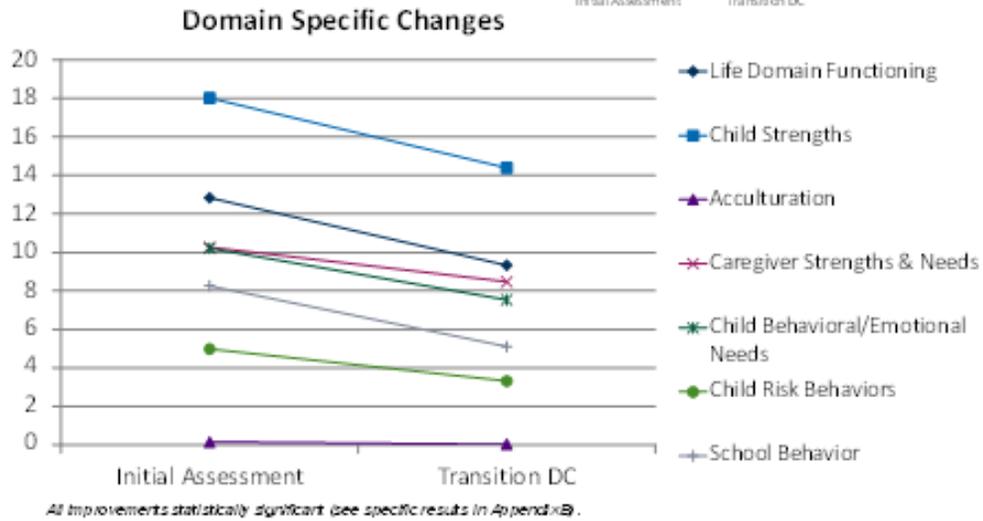
**All Children/Youth**

All Children/Youth included all CSoC members with a paired initial and discharge CANS submitted (n = 197).

- Global Score change from Initial → discharge = 12.91
  - Indicates statistically significant improvement (p < .001).
- Domain scores all decreased and continue in the desired direction
  - Indicates statistically significant improvement (p < .001 to .05 values).

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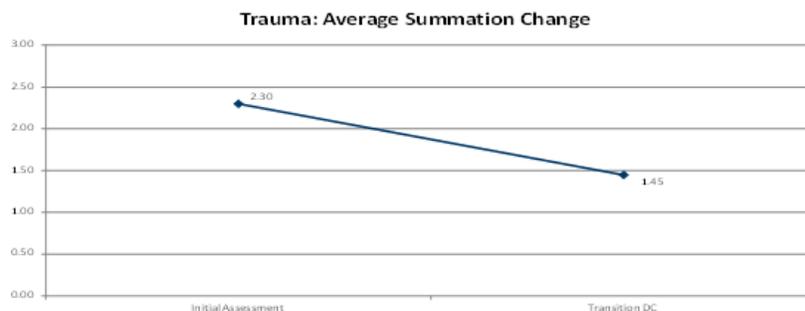
*Outcomes:*  
**All Children/Youth**



**Children/Youth with Trauma**

From the Child Behavioral/Emotional Needs Domain, the Trauma Module is triggered by the item question “Adjustment to Trauma.” The Trauma Module itself contains six (6) item questions related to history and description of trauma. Of those six questions, four (4) are related to adjustment to trauma: “Affect Regulation,” “Intrusions,” “Attachment,” and “Dissociation,” and help to derive outcomes. The Trauma average summation scores are computed using the trigger question + the four questions within the module. Improvement for the trauma module was statistically significant, 2.30 → 1.45, a change of 0.85 (p < .001).

*Outcomes: Children/Youth with Trauma Scores on Trauma Module*

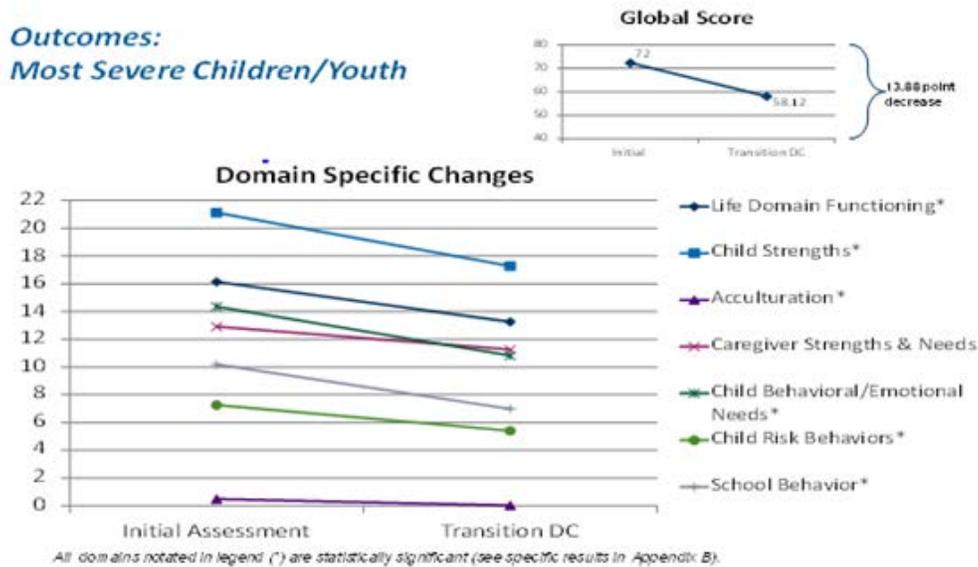


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**Most Severe Children/Youth**

Most Severe Children/Youth included a sub population representing the most severe Global Scores (upper Quartile). This subpopulation represents the Top 26%. The Top 25% (upper Quartile) were initially reviewed, but a few youth scores tied; thus, they were included in the count to arrive at the Top 26% being represented, N= 51.

- Global Score change from\_initial → discharge = 13.88 (statistically significant  $p < .001$ ).
- Domains listed below reflect a statistically significant change: (statistically significant at  $p < .001$ , .05 or .079 values).
  - Life Domain Functioning , Child Strengths, Acculturation, Child Behavioral/Emotional Needs, Child Risk Behaviors, and School Behavior



**XIII. Patient Safety**

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

Adverse incidents are defined as an unexpected occurrence in connection with services provided through Magellan, its subsidiaries and affiliates (Magellan), that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, to an individual

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receiving services through Magellan or a third party that becomes known to Magellan staff. Types of incidents can include:

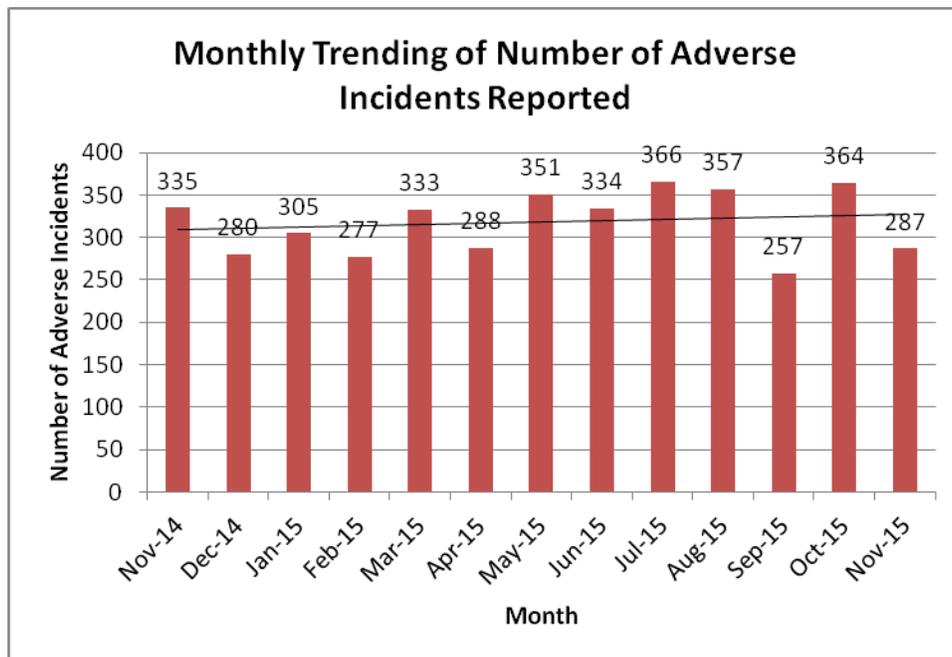
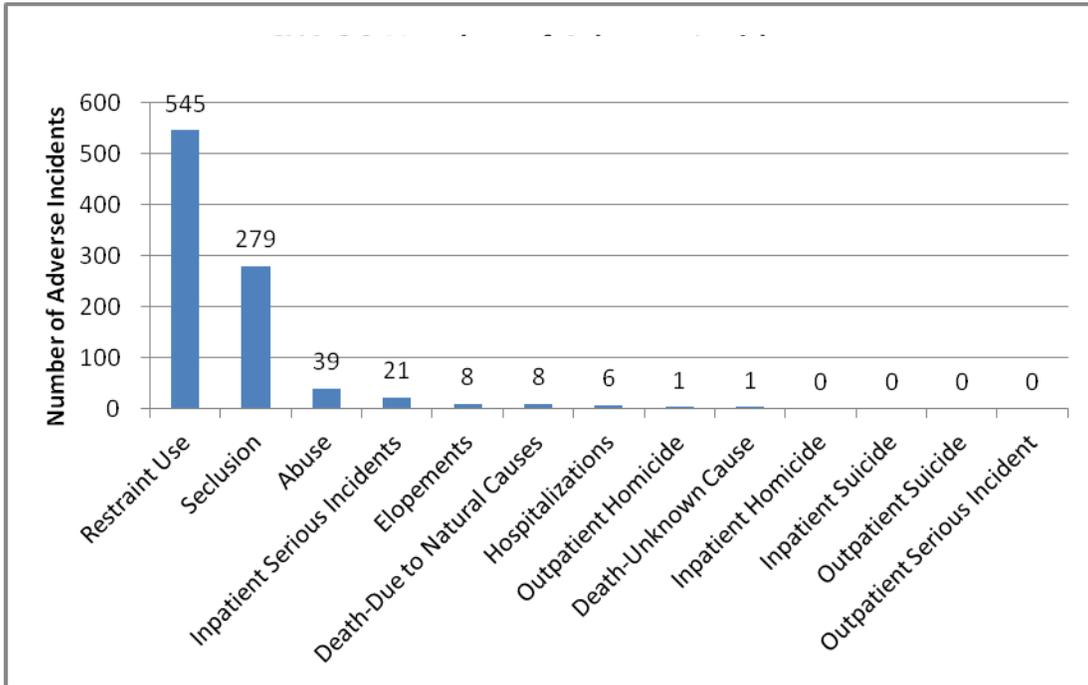
- Death
- Suicide Attempt
- Significant Medication Error
- Event Requiring Emergency Services (of the fire department or a law enforcement agency)
- Abuse (Physical Abuse, Psychological Abuse, Sexual Abuse, Extortion or Exploitation)
- Serious Injury or Illness
- Missing Person
- Seclusion or Restraint

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

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

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

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Restraints and seclusions represent the largest type of incidents reported. There was a slight upward trend in reports received. Magellan implemented a formal performance improvement project to improve reporting in contract year three that can be referenced in **Section V Quality Improvement Activities and Performance Improvement Projects**. Interventions for this project focused on improving

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provider awareness of reporting protocols and increasing accountability through augmented monitoring.

**XIV. Treatment Record Reviews and Clinical Practice Guidelines**

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

**Results**

Sixty-one (61) providers (n=608 charts) were reviewed for a TRR, Waiver and/or PIP Follow up review from March 1, 2015 through November 30, 2015 through the use of the web based auditing tool. The overall network compliance rate for contract year four was 89%, which is 9 percentage points above the 80% minimum threshold. Thirteen of the scored fifteen TRR Core sections overall scores were above the 80% minimum threshold, with eleven of those averaging from 89% to 100%. Three measures fell below the 80% minimum threshold, ranging from 65.8% to 78.3%. The chart below outlines section scores and provides a comparison of contract year three results. There were improvements in 12 of then nineteen sections. There were declines in 4 sections and 3 sections were not applicable for the providers reviewed. Three providers were referred to SIU based on information discerned in the process of a quality audits during this time period. Magellan addresses deficiencies at the provider and system level. Please refer to Performance Improvement Project and Opportunities for Improvement in this section for more details on these activities.

CORE Sections	Contract Year 4			Contract Year 3	Change (+/-)
	Elements Meeting Compliance	Elements Items	Compliance Rate (%)	Compliance Rate (%)	
A - General	2,329	2,342	94.80%	97%	-
B - Consumer Rights and Confidentiality	2,043	2,532	80.70%	73.54%	+

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C - Initial Evaluation	7,346	7,764	94.60%	91.91%	+
D - Individualized Treatment Plan	2,535.50	3,035	83.50%	81.26%	+
E - Ongoing Treatment	5,644	6,336	89.10%	85.24%	+
F - Addendum for Special Populations	336	365	92%	85.52%	+
H - Coordination of Care	779.5	1,185	65.8%	58.32%	+
I - Medication Management	937	1,052	89.10%	84.06%	+
Addendum - Access to Care	234	234	100%	98%	+
Addendum - Cultural	588.5	601	97.90%	93.33%	+
Addendum - Service Delivery	599.5	603	99.40%	96.55%	+
Addendum - Discharge	463	591	78.3%	81.57%	-
Addendum - Medication Management	339.5	468	72.5%	71.27%	+
Addendum – EBP: FFT	237	242	97.90%	98%	-
Addendum - EBP: MST	347.5	365	95.20%	97.28%	-
Addendum - EBP: Homebuilders	NA	NA	NA	96.56%	NA
Addendum - OBH/LGE Addendum	NA	NA	NA	24.57%	NA
Addendum – Restraints/Seclusion Totals	0	0	NA	100%	NA
Addendum - Adverse Incidents	1	1	100%	25%	+

**Level of Care Averages**

During contract year four, 608 charts were reviewed for 61 unique providers representing ten (10) levels of care as part of the TRR process. The levels of care reviewed during CY4 are CPST/PSR, Crisis Stabilization, Evidenced Based Practices (EBPs): ACT, EBP: FFT, EBP: MST, Inpatient, IOP, Non-Traditional Community Services, Outpatient, and Residential Substance Use Disorder.

Level of Care	Elements Meeting Compliance	Element Items	Averaged Score
CPST/PSR	8124.5	8968	90.6%
Crisis Stabilization	504	512	98.4%
EBP: ACT Assertive Community Treatment	6534	6904	94.6%
EBP: FFT Functional Family Therapy	1880.5	2085	90.2%
EBP: MST MultiSystemic Therapy	2364.5	2615	90.4%

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Inpatient Psychiatric Hospitalization	908.5	1025	88.6%
IOP SUD Intensive Outpatient Substance	436.5	569	76.7%
Non-Traditional Community Services	533	608	87.7%
Outpatient	2166.5	2860	75.8%
Residential Substance Use Disorder	431.5	496	87%

**Clinical Practice Guidelines**

Magellan develops or adopts clinical practice guidelines (CPGs) to assist providers in screening, assessing and treating common disorders. Prior to adopting each guideline, a multi-disciplinary panel—including board-certified psychiatrists and clinical staff—examines relevant scientific literature and seeks input from network providers as well as members and community agencies. Once implemented, Magellan reviews each guideline at least every two years for continued applicability and updates guidelines as necessary. Guidelines, when changed, are updated on the website and providers are notified of any change through the online newsletter. Magellan’s adopted guidelines are intended to augment, not replace, sound clinical judgment. The Clinical Practice Guidelines are available to all Magellan providers on the Magellan provider website. A list of the Clinical Practice Guidelines and a direct link to those guidelines is provided on the Clinical Practice Guidelines page of the Magellan of Louisiana website with the expressed requirement that all Magellan providers are responsible to be familiar with these guidelines. Both the Quality section of the Magellan of Louisiana web site and the Magellan’s Provider Handbook includes a PDF version of the CPG Audit tools.

The Louisiana Unit monitors CPGs for Major Depressive Disorder, ADHD, Substance Use Disorder, Schizophrenia, and Suicide Risk as part of its TRR process during contract year four. Data for contract year four indicates Major Depressive Disorder, Schizophrenia and Suicide Risk CPGs are above the 80% minimum compliance threshold, while CPGs for ADHD, Substance Use Disorder, were below the minimum performance threshold. Magellan addresses deficiencies at the provider and system level. Please refer to Performance Improvement Project and Opportunities for Improvement in this section for more details on these activities.

Clinical Practice Guidelines	Contract Year 4			Contract Year 3	Change (+/-)
	Elements Meeting Compliance	Elements Items	Compliance Rate (%)	Compliance Rate (%)	
Major Depressive Disorder	420	484	86.8%	87.6%	-
ADHD	135.5	224	60.5%	65.5%	-
Substance Use Disorder	183.5	251	73.1%	77.3%	-
Schizophrenia	271.5	330	82.3%	82.2%	-
Suicide Risk	384	442	86.9%	70.0%	+

**Performance Improvement Plans**

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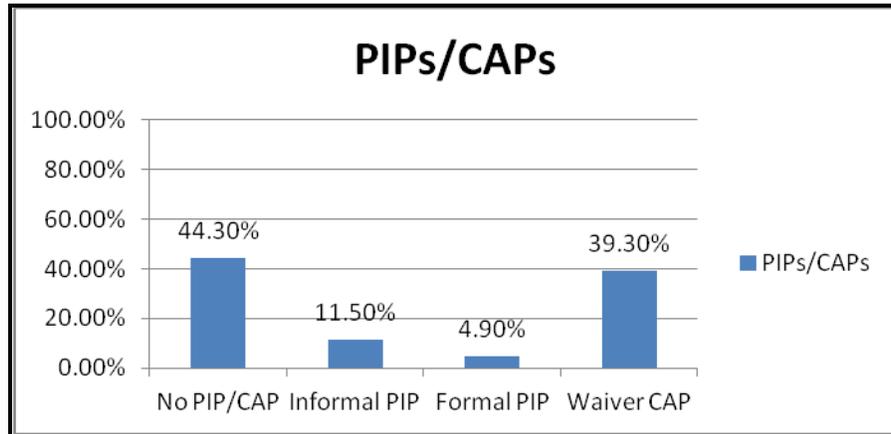
Magellan has adopted procedures for Performance Improvement Plans (PIPs) to be implemented for providers with overall scores below established thresholds. All reviewed providers are given feedback and suggestions on any area or item that did not meet the 80% standard, whether or not the provider was required to submit a PIP. Magellan has policies in place to require all providers who do not meet 100 percent compliance standards for 1915(i) State Plan Amendment and 1915(c) and 1915(b3) Waiver performance measures to submit a Performance Improvement Plan (PIP) on how they intend to address deficiencies. PIPs are viewed by Magellan not as punitive in nature but rehabilitative and constructive. Magellan Clinical Reviewers provide education and resources to providers to ensure an understanding of opportunities for improvement. Magellan disseminates a detailed results letters following a review that identifies the provider's strengths, opportunities for improvement, and any required corrective action plans. PIPs are implemented to address opportunities for improvement that have been identified in the TRR, ACT Fidelity, and Waiver Performance Measure processes for individual providers. Clinical reviewers take the initiative to offer and provide technical assistance to providers and monitor PIPs until accepted. The following guidelines are used to determine if a PIP is required:

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

The chart below depicts the number of PIPs and CAPs requested for CY4, March 1, 2015 – November 30, 2015. Of the 61 providers reviewed in CY4 twenty-seven (27) providers required no PIP/CAP, six (6) providers required an Informal PIP only, one (1) provider required both an Informal PIP and a Waiver CAP, twenty-four (24) providers required a Waiver CAP only, and three (3) providers required a formal PIP.

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Total Facilities Reviewed	Formal PIP	Informal PIP	Waiver CAP	Total PIPs/CAPs
61	3	7	24	34



**Opportunities for Improvement**

Magellan utilizes TRR data to collaborate with providers with the goal of improving the service provided to covered Medicaid Members. All data is analyzed for patterns and trends, such as categories that fall below the threshold over a period of time. When an aberrant pattern or trend is identified, the QI department conducts a root cause analysis and recommends interventions. This information is disseminated to the QIC to quickly identify where to focus improvement efforts. Magellan reviews this information continuously, so improvements to the system can be made on an ongoing basis. Macro network opportunities for improvement and key drivers of non-compliance for contract year four include:

- **Member Rights & Confidentiality**
  - Signed psychiatric advance directives.
  - Releases for communication with PCP and other relevant providers.
- **Individualized Treatment Plan**
  - Goals/objectives have timeframes for achievement
  - Use of preventive/ancillary services incl. community & peer supports considered
- **Ongoing Treatment**
  - Crisis Plan documented.
- **Coordination of Care**
  - Documentation of request to member for PCP communication.
  - Record reflects continuity and coordination of care between behavioral health providers.

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- **Discharge Planning and Process**
  - Discharge plan included an appointment date and time with Primary Care Physician if medical co-morbidity was present. If not, the reason was documented.
  - Medication profile was reviewed with outpatient provider at time of transition of care
  - Medication profile was reviewed with member at time of transition of care
- **Addendum: Medication Management**
  - AIMS performed and documented if member is being treated with antipsychotics.
  - Provider documented ongoing screening or weight, BMI at intervals and annual screening of fasting glucose and lipids for members being treated with antipsychotics.
- **Clinical Practices Guidelines**
  - ADHD
  - Substance Use Disorders

In contract year four, interventions continued to assist the overall provider network to better understanding documentation requirements as well as to provide education and resources to providers. A training reviewing the primary areas of deficit on the Treatment Record Review, with specific suggestions for remediation, was presented during the August 2015 All Provider Call and was uploaded to the provider web page. Resources have been maintained and updated, including tip sheets on advance psychiatric directives, initial evaluations, writing treatment plans and writing progress notes as well as sample templates for crisis/safety plans, discharge plans, informed consent for medications, and member rights and responsibilities (English and Spanish versions), and suicide risk assessment tip sheets were uploaded on the Quality page of the Magellan of Louisiana web site. Monthly reminders of these resources are given at each All Provider Call as well as at each individual audit. Additional trainings were provided during the monthly All Provider calls on Treatment Plan Development in June 2015 and on Cultural Competency in May 2015.

Additional educational efforts focused on compliance in the area of processes and documentation related to review and updating of the 1915(i) Plan of Care. An email blast was sent to all 1915(i) CPST/PSR providers educating them on the required review of the member's Plan of Care at 90 days. This was reinforced by a random review of the documentation of the 90 day Plan of Care review during June 2015. The update of Plans of Care for members that warrant a change in their Plan of Care, prior to their yearly Independent Assessment, was also reviewed for improvement in September 2015.

#### **XV. Inter-rater Reliability**

Magellan provides extensive ongoing training and consultation to Care Managers to ensure the appropriateness and quality of our clinical services. We use a multi-faceted approach to monitoring the accuracy, appropriateness, and timeliness of care management activities and provide training for any

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areas requiring improvement. The following are some of the processes we use to ensure inter-rater reliability when making medical necessity determinations:

- **Clinical Rounds/Case Conferences:** A stimulating educational forum for clinicians to enhance their expertise and skills in diagnostics, crisis management, service authorization criteria, and community resource knowledge. During the rounds/case conference (one-on-one or group), Care Managers have the opportunity to present challenging or problematic cases. At least one supervisor will be present, including a member of the medical team. The presentation is followed by a discussion of the clinical issues of the case, which often results in suggestions or recommendations for improvement, highlighting teaching points of the case, or suggesting other interventions or consultations that could have been attempted. Medical necessity and proper interpretation of criteria will be an integral part of the discussion.
- **Inter-rater Reliability Studies:** Magellan’s clinical policy provides for annual measurement of the consistency of application of service authorization criteria by care management staff, Physician Advisor Consultants, and Medical Directors. The measurement process conforms to customer, NCQA, URAC, and licensing requirements. The annual inter-rater reliability study establishes a process with all clinicians reviewing an identical set of vignettes to measure the national inter-rater reliability performance rate. Information gained from these inter-rater reliability reviews will be used for individual or departmental clinical training.
- **Training:** On a regular basis, Magellan offers clinical training sessions. For Magellan to meet its goal to provide the right service at the right time for the right amount of time, the clinical staff receives ongoing education to ensure clinical best practices and processes are being followed. The training sessions address topics that are critical to the clinical staff’s performance with regard to the accuracy and appropriateness of authorization determinations.
- **Call Monitoring:** Magellan uses the Qfiniti Enterprise suite, a comprehensive and integrated system that records calls and enables us to deploy proven, scalable quality monitoring and Care Manager evaluation programs. Through analysis capabilities, we can determine mentoring and coaching opportunities for Care Managers. Evaluation tools for care managers include questions on the following core performance areas: clinical content and documentation; utilization review; recovery and resiliency; timeliness of reviews, notification, and data entry; adverse determination, denial, and review notification; and motivational interviewing. Each month, clinical supervisors audit three calls for each Care Manager. Results from a Care Manager’s audits are reviewed with the individual and the results from the full care management department are aggregated per team. This process provides information for direct supervision and prompt remediation when concerns are noted.

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- **Documentation Audits:** These are incorporated into Qfiniti audit capabilities. Magellan’s clinical supervisors complete at least three clinical documentation audits per Care Manager, per month, with a target of 90 percent compliance or better. The audits monitor compliance with policy, customer-specific requirements, and accreditation requirements. Care Managers receive copies of their monthly audits and are coached in areas of documentation noncompliance.
- **Ongoing Data Analyses and Reporting:** Magellan conducts numerous ongoing data analysis and reporting activities that will yield daily, weekly, monthly, and other results and formal reports. As one example, the Clinical Non-Authorization Overturn Rate is often included in Magellan’s Quality Work Plan. It is an indicator to monitor the rate of clinical non-authorizations which are overturned during the appeal process. For each month in which this rate is greater than 20 percent, our Medical Director reviews the cases which were overturned to determine if there is a trend that can be further analyzed and applied to future service authorization criteria determinations. Building this process into routine oversight activities ensures that Magellan is applying a CQI approach in their monitoring activities. The results can also be used for Care Manager training purposes.

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

## **XVI. Evidence-Based and Best Practice Initiatives**

Our QM approach promotes a Member-centered, recovery and resiliency-oriented, evidence-based behavioral health care model consistent with Louisiana’s goals. It focuses on driving and rewarding quality; measuring, assessing, and continually improving participant outcomes; and promoting the use of evidence-based practices. The Louisiana Unit authorizes a variety of evidence-based practices, including Assertive Community Treatment (ACT), Multi-systemic therapy (MST), Homebuilders, Functional Family Therapy (FFT), Child-Parent Psychotherapy (CPP), and Parent Management Training. This section describes each practice and discusses utilization trends.

### **A. Assertive Community Treatment (ACT)**

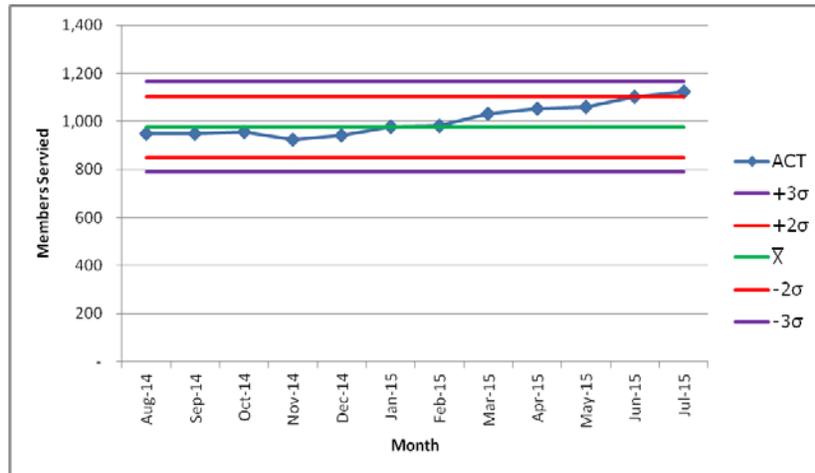
ACT services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictive disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual’s ability to cope and relate to others and enhancing the highest level

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of functioning in the community. Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination. The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the member. The majority of ACT services are provided in the community by multidisciplinary teams. The primary goals of the ACT program and treatment regimen are to:

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

There were sixteen contracted ACT teams that serving members in contract year four. The below graph depicts the strong upward trend in members being served through ACT.



**Fidelity Monitoring**

As of March 2015, there were 16 ACT teams across the state. Fourteen of these teams were fully-functioning teams, serving between 80-100 members. The other two teams were “startup” teams, serving less than 50 members. During contract year four, Magellan surveyed and reviewed the fidelity self-assessments of Assertive Community Treatment (ACT) programs statewide. ACT teams were required to complete a Dartmouth Assertive Community Treatment Scale (DACTS) self-assessment fidelity review from the Substance Abuse and Mental Health Services Administration (SAMHSA) tool kit

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*Assertive Community Treatment: Evaluating Your Program.* Additionally, the teams were required to complete the Magellan ACT Fidelity Review Survey questionnaire, which obtains staff names, degrees, and work experiences. It also documents program components, such as the frequency of individual and group therapy.

Using the SAMHSA toolkit, the teams scored themselves on the DACTS and submitted this information along with the Magellan ACT Fidelity Review Survey to the Magellan Quality Improvement (QI) team. The QI team reviewed and tallied the fidelity review results, contacting teams to clarify any issues. The teams were scored using the suggested SAMHSA DACTS score cut-offs for Good, Fair, or Poor. The fourteen fully-functioning teams scored Good (i.e., 113 or higher out of 140) on the DACTS. The two start-up teams scored lower, which was expected, but they were able to assess their strengths and weaknesses to help ensure good fidelity to the ACT model, when they reach fully-functioning status.

The chart below provides a comparison of DACTS results for the 14 fully-functioning ACT teams. The minimum performance threshold is provided in the second column for each metric, and the network mean is also provided in the far right column. All providers were functioning at higher than the minimum performance threshold for all categories. Each provider had a DACTS Total score of 113 or above, which is the “Good” category for fidelity according to the SAMHSA toolkit. No providers required an onsite fidelity audit. The main opportunities for improvement were in the DACTS Nature of Services, specifically Work with Support System (DACTS Item S5) and Frequency of Service (DACTS Item S6).

ACT Provider and Team	DACTS Total	DACTS Fidelity Level
<b>Minimum Performance Threshold</b>	<b>84</b>	<b>Fair</b>
NHS BR	123	Good
VOA Laf	119	Good
FPS Met	114	Good
NHS Shrev	125	Good
NHS Laf	125	Good
NHS LC	117	Good
RHD Metro 1	121	Good
RHD Metro 2	123	Good
RHD Jeff 1	114	Good
RHD Jeff 2	119	Good
NHS Alex	117	Good
NHS NO 1 ACT	133	Good
NHS NO 2 FACT	126	Good
CBS Shrev	125	Good
<b>Provider Mean</b>	<b>121.5</b>	<b>Good</b>

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**ACT Scorecard**

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

**B. Multi-systemic therapy (MST)**

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

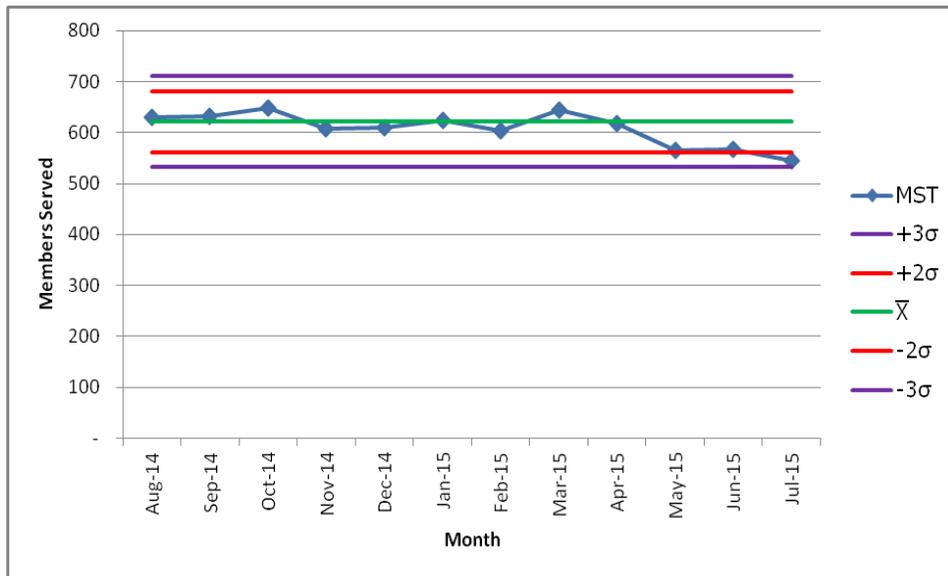
MST is designed to accomplish the following:

- Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care.
- Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others.
- Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities.
- Help caregivers develop effective parenting skills and skills to manage the member’s mental health needs, improve caregiver decision-making and limit setting.
- Improve family relationships.

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- Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardies and/or a decrease in job terminations.
- Support involvement in restorative measures, such as community services, if involved with Juvenile Justice.
- Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.).
- Develop natural supports for the member and family.

There was a downward trend in MST utilization beginning in May 2015. This can be attributed to the closing of two MST teams. Decreases in grant money and costs associated with providing the services were cited for the closure of the teams.



In the end of contract year four, Magellan, in collaboration with MST Institute, conducted a cost analysis report that was submitted to DHH-OBH in December 2015. This report outlines cost associated for members who receive MST.

**Louisiana Behavioral Health Partnership: Multisystemic Therapy Cost Report**

**Purpose**

The Louisiana Medicaid State Plan provided Multisystemic Therapy (MST) through the Louisiana Behavioral Health Partnership, managed by Magellan Health Services, starting in 2012. MST is an intensive family- and community-based treatment program that focuses on addressing all environmental systems that impact youth at risk of out-of-home placement due to externalizing behavior symptomatology. The youth and their families have ongoing multiple system involvement due

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to high risk behaviors. Considerable evidence points to the effectiveness of MST in keeping youth at home, in school, and out of trouble with the law.

This report focuses on assessing the impact of MST on the overall behavioral health costs for the population of 3,112 youth discharged from an MST program between 3/1/2013 and 3/1/2015 that had an opportunity for a full course of treatment. This date range was chosen to allow Magellan to have adequate data both pre- and post-MST to generate an accurate picture of total health care costs.

Descriptive information about the youth served is as follows:

- male (65%), female (35%)
- black (64%), white (23%), Hispanic/Latino (8%), Multi-racial (4%)
- referred by juvenile justice (49%), education (16%), mental health (11%), social services (6%), other (18%)

The outcomes obtained for these youth at discharge for this group exceeded the targets set by MST Services and showed the following:

- 93.3% were living at home
- 92.6% were in school or working
- 91.6% had no new arrests during treatment

## **Methodology**

### **Sample**

The MSTI database list was used to identify the sample. Magellan Health matched this to their records (see Data Sources below) using full name and date of birth. The resulting sample size was 1,644 (47% of population). The following inclusions and exclusions were applied:

- Duplicate members removed
- MST first visit date and discharge date allow for a 180-day pre-MST period and 180-day post-MST period between 3/1/2012 and 7/31/2015 (to allow for claims lag)
- No MST units in pre-MST period and post-MST period
- Total sample defined as Case Progress codes 1 through 3; Completers defined as Case Progress 1; Non-Completers defined as Case Progress codes 2 and 3.
- Treatment length  $\geq$  0 days included.

### **Time Periods**

The following time periods are used for the pre, concurrent, and post groups:

- 180 day pre-MST period starts 180 days prior to MST first visit date
- MST period goes from MST first visit date to MST discharge date

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- 180 day post-MST period goes from MST discharge date to 180 days after discharge date

**Metrics**

Specifications that were applied to reported metrics include:

- Metrics with Averages are taken using the total # members in the sample
- Ns in service breakdowns are contributor counts and not used in the denominator for averages
- ALOS: all IP encounters whose service start dates are in the designated period are included
- IP MH/SA claims are based on authorization outcome codes

**Data Sources**

The following data sources were used in this report:

- MSTI Database List
- Louisiana\_auths..authorized\_admissions
- Louisiana\_Claims.dbo.comprehensive\_claims\_paid
- Louisiana\_Claims..COSTCENTERPLANS
- Louisiana\_Claims..BENEFITLEVELOFCAREXREF
- Louisiana\_Claims..MDRPTB\_MBC
- Louisiana\_Claims..CLAIMAUTHXREF
- Louisiana\_Eligibility..EnrollmentDemographics

**Considerations**

- Report Run Date: November 19, 2015
- Data are dynamic and cost metrics are based on claims. Claims can be submitted up to 365 days from the date of services. Magellan applied a 90 day claims lag; however, results could change dependent on date report is run due to claims submissions, claims disputes, and retroactive eligibility determinations.
- The report does not capture potential cost saving realized from deterring member placement in state custody as a result of the service delivery.
- The report would be more meaningful with the inclusion of a control group; however, there was not an identifiable anchoring event comparable to the referral to MST that was trackable in Magellan’s systems. The MSTI Database did not include a large enough group of individuals (n=18) that were referred to MST but did not engage to be used as a comparison group.

**Service Descriptions**

Service Acronym	Service Name	Service Description
IP MH/SA	Inpatient Mental	Out of Home (OOH) Placement

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	Health/Substance Use	
Crisis Int	Crisis Intervention	Crisis Service
PSR	Psychosocial Rehabilitation	Outpatient Home and Community Based Service (HCBS)
Other	Other Outpatient Services	Lab, Outpatient Therapy, etc.
CPST	Community Psychiatric Support and Treatment	Outpatient Home and Community Based Service (HCBS)
PRTF	Psychiatric Residential Treatment Facility	Out of Home (OOH) Placement
NMGH	Non-Medical Group Home	Out of Home (OOH) Placement
FFT	Family Functional Therapy	Intensive Evidenced Based Practice (EBP) Outpatient
HBR	Homebuilders	Intensive Evidenced Based Practice (EBP) Outpatient
IOP	Intensive Outpatient	Outpatient
CSoc YST	Coordinated System of Care Youth Support and Training	Intensive Evidenced Informed Practice (EBP) Outpatient
CSoc PST	Parent Support and Training	Intensive Evidenced Informed Practice (EBP) Outpatient
CSoc STR	Short Term Respite	Intensive Evidenced Informed Practice (EBP) Outpatient
CSoc ILSB	Independent Living and Skills Building	Intensive Evidenced Informed Practice (EBP) Outpatient

**Results**

**Overall Outcome Metrics**

**Total Sample (N= 1645)**

Metric	180-Day Pre-MST	MST	% Change	180-Day Post MST	% Change
Avg # IP Admits Per 100 Sample Members	9.00	6.87	-23.65%	4.74	-47.30%
Avg # IP Days	0.75	0.49	-34.72%	0.42	-43.74%
ALOS IP	7.74	8.39	8.34%	7.09	-8.44%
Avg Amount Paid Claims	\$1,215.13	\$7,621.81	527.24%	\$1,192.26	-1.88%

**Completers (N = 1483)**

Metric	180-Day Pre-MST	MST	% Change	180-Day Post MST	% Change
Avg # IP Admits Per 100 Sample Members	8.43	6.00	-28.80%	4.59	-45.60%
Avg # IP Days	0.69	0.41	-41.17%	0.32	-54.37%
ALOS IP	7.57	6.90	-8.84%	6.88	-9.06%
Avg Amount Paid Claims	\$1,175.79	\$7,947.14	575.90%	\$954.32	-18.84%

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**Non-Completers (N = 162)**

Metric	180-Day Pre-MST	MST	% Change	180-Day Post MST	% Change
Avg # IP Admits Per 100 Sample Members	14.20	14.81	4.35%	6.17	-56.52%
Avg # IP Days	1.23	1.22	-1.50%	1.37	11.00%
ALOS IP	8.70	13.92	60.04%	8.50	-2.25%
Avg Amount Paid Claims	\$1,575.29	\$4,643.68	194.78%	\$3,370.46	113.96%

**Service Breakdown Using Average Amount Paid Claims**

**Total Sample (N= 1644)**

180-Day Pre-MST			MST			180-Day Post MST		
Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims
IP MH/SU	165	\$481.42	MST	1585	\$7,161.59	PRTF	16	\$292.25
Crisis Int	56	\$145.54	IP MH/SU	114	\$288.82	IP MH/SU	104	\$282.48
PSR	178	\$138.93	Other	665	\$106.61	NMGH	29	\$150.54
Other	574	\$118.28	NMGH	5	\$23.71	PSR	176	\$105.81
CPST	182	\$111.38	PSR	45	\$14.70	Other	469	\$97.46
PRTF	5	\$110.13	CPST	52	\$13.25	CPST	186	\$95.99
NMGH	12	\$59.31	PRTF	3	\$6.93	Crisis Int	28	\$58.97
FFT	16	\$15.34	IOP	7	\$2.89	IOP	16	\$43.90
HBR	8	\$13.59	FFT	5	\$1.39	FFT	32	\$30.35
IOP	11	\$13.37	CSoc YST	1	\$0.84	HBR	11	\$19.90
CSoc YST	10	\$5.31	Crisis Int	3	\$0.83	CSoc PST	20	\$5.44
CSoc PST	6	\$2.40	CSoc PST	1	\$0.25	CSoc YST	10	\$3.69
CSoc STR	1	\$0.09				TGH	1	\$3.47
CSoc ILSB	1	\$0.04				CSoc STR	2	\$1.63
						CSoc ILSB	1	\$0.37

**Completers (N = 1483)**

180-Day Pre-MST			MST			180-Day Post MST		
Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims
IP MH/SU	140	\$440.74	MST	1441	\$7,537.20	IP MH/SU	83	\$227.01
Crisis Int	53	\$155.45	IP MH/SU	88	\$245.14	PRTF	9	\$163.33
PSR	162	\$142.83	Other	597	\$104.63	NMGH	19	\$110.43
Other	507	\$114.70	NMGH	3	\$25.58	PSR	161	\$108.51
CPST	167	\$113.33	PSR	40	\$15.48	CPST	170	\$96.15
PRTF	4	\$98.86	CPST	45	\$13.76	Other	410	\$95.40
NMGH	10	\$63.04	IOP	6	\$3.07	Crisis Int	26	\$61.83

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180-Day Pre-MST			MST			180-Day Post MST		
Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims
FFT	15	\$15.21	FFT	3	\$1.37	IOP	10	\$39.66
HBR	7	\$13.08	Crisis Int	3	\$0.92	FFT	29	\$30.71
IOP	8	\$10.70				HBR	7	\$13.09
CSoc YST	8	\$5.29				CSoc PST	15	\$4.99
CSoc PST	4	\$2.41				CSoc STR	2	\$1.81
CSoc STR	1	\$0.11				CSoc YST	9	\$0.98
CSoc ILSB	1	\$0.04				CSoc ILSB	1	\$0.42

**Non-Completers (N = 162)**

180-Day Pre-MST			MST			180-Day Post MST		
Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims	Service	N	Avg Amount Paid Claims
IP MH/SU	25	\$853.78	MST	144	\$3,723.13	PRTF	7	\$1,472.43
PRTF	1	\$213.31	IP MH/SU	26	\$688.71	IP MH/SU	21	\$790.33
Other	67	\$151.09	Other	68	\$124.75	NMGH	10	\$517.69
PSR	16	\$103.21	PRTF	3	\$70.41	Other	59	\$116.37
CPST	15	\$93.57	CPST	7	\$8.61	CPST	16	\$94.52
Crisis Int	3	\$54.87	CSoc YST	1	\$8.52	IOP	6	\$82.68
IOP	3	\$37.84	PSR	5	\$7.59	HBR	4	\$82.24
NMGH	2	\$25.13	NMGH	2	\$6.61	PSR	15	\$81.13
HBR	1	\$18.22	CSoc PST	1	\$2.53	TGH	1	\$35.19
FFT	1	\$16.56	FFT	2	\$1.56	Crisis Int	2	\$32.73
CSoc YST	2	\$5.43	IOP	1	\$1.25	CSoc YST	1	\$28.52
CSoc PST	2	\$2.28				FFT	3	\$27.08
						CSoc PST	5	\$9.55

**Discussion**

Since a comparison group could not be established, an estimate of what costs might be for a similar group of young people without MST can not be calculated. The data set only includes costs associated with health care payments and does not capture potential cost saving realized from deterring member placement in state custody as a result of the service delivery. Given that almost half of the referrals came from juvenile justice and one of the eligibility requirements for MST is risk of out-of-home placement, we can assume that some proportion of the sample would have been placed if not for MST. However, Magellan did not have data from the Office of Juvenile Justice that was in a format to assist with this project. Therefore, this report is not able to provide a full picture of cost savings associated with MST.

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Comparison of costs for the youth who did not complete treatment with those that did have the benefit of a full course of treatment found that completers had a 19% reduction in cost of paid claims post MST while youth who did not receive a full course of treatment saw a 114% increase, a difference of \$2,416.12 for the 180 day period. The groups may not be completely comparable; however, analyses were not conducted to determine if the differences were statistically significant. Results showed that non-completers were more likely to have had an inpatient hospitalization (15%) and have more inpatient days pre-MST than MST completers (9%). They also had almost twice as many average inpatient days (1.2 vs. .69, respectively) pre-MST. It may be helpful at some point to conduct case reviews of a sample of the non-completers with a more intensive service post-MST to determine if this outcome was the result of poor implementation of MST or a poor match between the MST service and youth's needs.

### **C. Homebuilders**

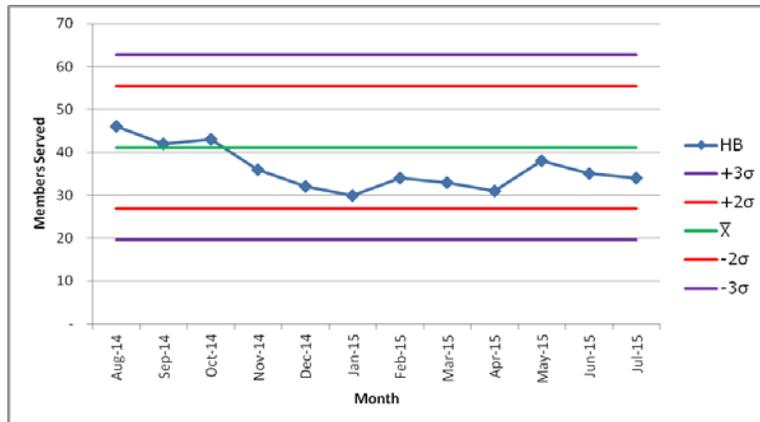
Homebuilders is an intensive, in-home Evidence-Based Program (EBP) utilizing research based strategies (e.g. Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (birth to 18 years) at imminent risk of out of home placement,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

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

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

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There was a flat trend in the utilization of Homebuilders in contract year four as evidenced in chart below.



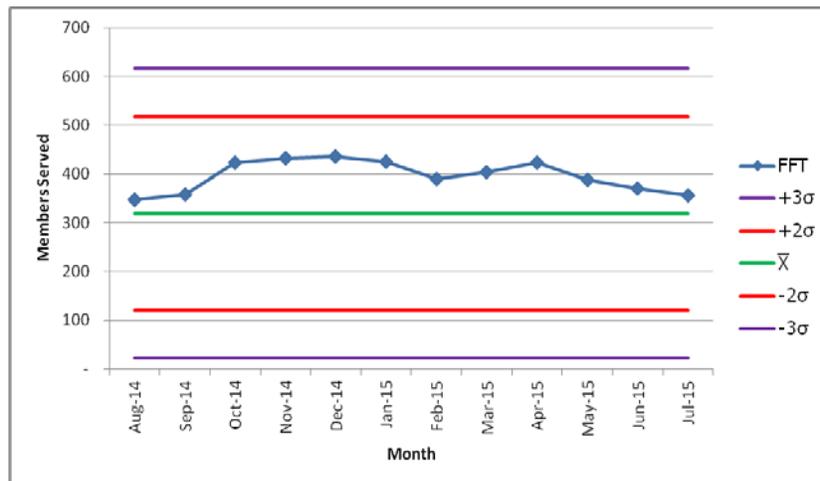
**D. Functional Family Therapy (FFT)**

Functional Family Therapy (FFT) is an evidenced based family intervention targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth may also meet criteria for a disruptive behavior disorder (ADHD, oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and behavioral health issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment.

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

There was a flat trend in FFT utilization in contract year four as evidenced in chart below.

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**E. Other EBP Initiatives**

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

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

Providers completing the trainings and any providers previously trained (list supplied by the universities) will be considered preferred providers for members in this age group who may indicate need for this clinical practice. In order to be selected to participate, a provider must be a Louisiana Licensed Mental Health Practitioner (i.e., Psychologist, Clinical Social Worker, Professional Counselor or Marriage and Family Therapist). Interested providers are required to submit an application to participate and must commit to participate in the entire training series (face-to-face sessions and monthly consultation calls). Selection is based on provider qualifications, geographical location, willingness to commit to all of the required trainings and consultation calls, etc. Currently, the LBHP allows twenty-four (24) pass-through outpatient therapy sessions to be provided to young children. It is our goal to build a network of providers who are trained/certified in evidence-based treatments for

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children birth through 6 years of age. As this occurs, Magellan will reduce the use of providers who do not have these skills for the young child population and, over time, the pass through sessions will be reduced significantly for non-trained/certified providers.

**Child-Parent Psychotherapy (CPP)**

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

Training for CPP consists of an initial three-day training session, two phone consultation calls per month for 18 months following the initial training session and two additional two-day follow up training sessions at 6 month intervals. In order to become a certified trained CPP Therapist, providers must participate in 18 months of training and phone consultations. Training costs, including training materials are covered by Magellan and the LSU Health Sciences Center.

**Parent Management Training**

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

Training for Parent Management Training consists of an initial two-day training session followed by the next two-day training session 1 month later, twenty-four consultation phone conferences (one every

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other week), and one day of advanced live training 6 months after the initial training. In order to become a certified trained PMT Therapist, providers must participate in all training sessions and consultation phone conferences. Training costs, including training materials are covered by Magellan and Tulane Medical Center.

**XVII. Behavioral Continuum (System Transformation)**

In addition to the traditional managed care pieces of our organizational approach, Magellan has implemented a system transformation component to our work in Louisiana. The Coordinated System of Care is a central program that is managed by Magellan’s System Transformation Department.

The Coordinated System of Care (CSoC) was developed in Louisiana in 2012 as a new approach to offering behavioral health care services for children/youth and their families that is based on system of care values. The goal of CSoC is to make sure families who have children with severe behavioral health challenges get the right support and services, at the right time, for the right amount of time, from the right provider, to keep or return children home or to their home communities.

The program was initially implemented in five of the nine regions of the state and was implemented in all regions in November 2014. The initiative creates a single point of entry for families of children who have complex behavioral health needs and are either in or at risk of being in out-of-home placement (e.g. foster homes, group homes, juvenile detention facilities, residential treatment centers) by combining resources of the State of Louisiana's four child-serving agencies: Department of Children and Family Services, Department of Education, Department of Health and Hospitals and, Office of Juvenile Justice. Because children with serious mental health or substance use problems often are involved with many state agencies, CSoC provides a mechanism to bring all of these together into one coordinated network to offer the right services at the right time at the right level of intensity.

Families enrolled in CSoC receive intensive, individualized services in their communities. In this process, the family and child partner with a team of people they choose and work together to develop a plan that meets their needs, rather than having other people develop a plan for them.

Combining all services into one coordinated plan allows for better communication and collaboration among families, youth, state agencies, providers and others who support the family. Children and families enrolled in CSoC will be eligible for all of the services available through Medicaid plus specialized treatment planning and services offered through CSoC. In particular, these families will be able to receive:

- Wraparound Facilitation
- Parent support & training
- Youth support & training

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- Short-term respite
- Independent Living Skills and Skills Building
- Crisis stabilization (scheduled to be moved into the State Plan)

Source: <http://csoc.la.gov/>

**Demographic Data**

The CSoc Program continues to show increases in referrals to the program as reflected in the chart below. There was an 11.9% increase in the total referrals from September to December 2015.

Region	9/24/2015	12/31/2015	Increase
Region 1 – Orleans/Jefferson area	1538	1678	140
Region 2 - Baton Rouge area	1729	1884	155
Region 3 – Covington area	396	577	181
Region 4 - Thibodaux area	267	374	107
Region 5 – Lafayette area	321	390	69
Region 6 – Lake Charles area	204	274	70
Region 7 - Alexandria area	1030	1115	85
Region 8 – Shreveport area	1687	1777	90
Region 9 - Monroe area	1118	1207	89
Total	8290	9276	983

This translates into higher number of children enrolled in CSoc. There was a 13.7% increase in youth enrolled in CSoc from September to December 2015. Regional data are provided below.

Region	9/24/2015	12/31/2015	Increase
Region 1 – Orleans/Jefferson area	378	414	36
Region 2 - Baton Rouge area	270	278	8
Region 3 – Covington area	155	244	89
Region 4 - Thibodaux area	170	237	67
Region 5 – Lafayette area	92	97	5
Region 6 – Lake Charles area	90	112	22
Region 7 - Alexandria area	155	169	14
Region 8 – Shreveport area	218	196	(-22)
Region 9 - Monroe area	258	284	26
Total	1786	2031	245

The race/ethnicity and gender of youth served remains consistent with a majority of the youth served being African-Americans males. See details in charts below.

Race	Number	Percentage
African-American	1173	57.76%

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Caucasian	666	32.79%
Unspecified	128	6.30%
Other Ethnicity	43	2.12%
Pacific Islander	11	0.54%
American Indian	8	0.39%
Asian	2	0.10%
Total	2031	100.00%

Gender	Number	Percentage
Male	1302	64.10%
Female	727	35.80%
Unspecified	2	0.10%
Total	2031	100.00%

CSoC continues to primarily serve the target population ages 13-16 as reflected in the chart below.

Age Groups	Number
up to 4	47
5 - 8	336
9 - 12	605
13 - 16	796
17 - 21	245
Unspecified	2
Total	2031

**WAA Scorecard**

Magellan disseminates a quarterly report, issued to reflect calendar quarters, that provides de-identified regional and system aggregate achievement on thirteen metrics, eleven of which are derived using claims data. The report is compiled approximately 60 days after the reporting period to accommodate claims lag. Throughout CY4, the reporting categories included: % of Members Utilizing 1 or more CSoC Services Per Month; % of Members Utilizing 1 or more HCBS Services Per Month; POC Compliance Rate; WAA Fidelity Scores; # of Admits to inpatient Psych Hospital per 1000; Inpatient Psych Hospital ALOS; Inpatient Psych Hospital readmit Rate; # of Admits to Psychiatric Residential Treatment Facility (PRTF) per 1000; PRTF ALOS; PRTF Readmit Rate; Out of Home Placement; Out of Home Placement ALOS; and Out of Home Placement Readmit Rate. For Contract year four, the out of home placement report includes only the six placement types for which claims data is received: Inpatient hospital, PRTF, Non-Medical Group Home (NMGH), Therapeutic Foster Care (TFC), TGH, and Residential Substance Abuse Treatment.

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Changes in the Scorecard will be made for the CSoC Contract to align the scorecard with new reporting requirements outlined in the Quality Strategy Improvement document and changes in services managed by Magellan. New metrics will include: % of Members Utilizing 1 or more CSoC Services Per Month, % of Members Utilizing 1 or more HCBS Services Per Month, Plan of Care Compliance Rate, Number of Members Discharged from Inpatient, Inpatient Psych Hospital ALOS, Inpatient Psych Hospital readmit Rate, Access to Wraparound: Percent of youth meeting timely contact standard, Access to Wraparound: Percent of youth meeting timely face-to-face standard, CANS: Percent of youth showing improved clinical functioning in CSoC, CANS: Percent of children showing improved school functioning in CSoC, CSoC Average Length of Stay, Percent of children whose living situation at discharge is a HCB setting, and Percentage of members with at least one natural/informal support on CFT.

The 2015 Q3 Scorecard is provided below. There were improvements in nine of the thirteen measures, including improvements in utilization of HCBS and CSoC services. The fidelity measure is an annual measure and was not updated. PRTF readmissions showed no change across quarters and remained at the highest level of achievement (0% readmissions).

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**WAA Scorecard Q3 2015**  
 July-Sept 2015

% of Members Utilizing 1 or more CSoc Service Per Month				
	Less than 90%	90-99%	Equal 100%	
	Previous Quarter	Q3 2015	Progress	
Aggregate	77.4%	78.2%		
Region A	70.1%	72.5%		
Region B	88.8%	90.5%		
Region C	71.7%	74.5%		
Region D	81.6%	78.3%		
Region E	62.8%	60.6%		
Region F	67.7%	69.7%		
Region G	77.1%	81.3%		
Region H	83.4%	85.5%		
Region I	74.7%	77.3%		

% of Members Utilizing 1 or more HCBS Service Per Month				
	Less than 80%	80% - 90%	90% or Higher	
	Previous Quarter	Q3 2015	Progress	
Aggregate	51.8%	53.2%		
Region A	58.5%	58.4%		
Region B	56.3%	59.0%		
Region C	35.2%	40.9%		
Region D	53.5%	54.7%		
Region E	50.5%	51.9%		
Region F	26.1%	28.0%		
Region G	29.2%	32.1%		
Region H	64.4%	65.2%		
Region I	55.7%	56.4%		

Plan of Care Compliance Rate				
	Less than 80%	80% - 90%	90% or Higher	
	Previous Quarter	Q3 2015	Progress	
Aggregate	84.7%	93.3%		
Region A	92.3%	100.0%		
Region B	100.0%	93.3%		
Region C	80.0%	100.0%		
Region D	100.0%	100.0%		
Region E	60.0%	80.0%		
Region F	100.0%	100.0%		
Region G	100.0%	100.0%		
Region H	100.0%	100.0%		
Region I	100.0%	66.7%		

WAA Fidelity Scores				
	Less than 80%	80% - 90%	90% or Higher	
	Previous Year	Current Year	Progress	
Aggregate	100.0%	100.0%		
Region A	100.0%	100.0%		
Region B	100.0%	100.0%		
Region C				
Region D	100.0%	100.0%		
Region E				
Region F				
Region G				
Region H	100.0%	100.0%		
Region I	100.0%	100.0%		

Number of Admits to Inpatient Psychiatric per 1000				
	Greater 30	10 - 30	Less than 10	
	Previous Quarter	Q3 2015	Progress	
Aggregate	8.09	11.31		
Region A	10.51	16.27		
Region B	11.95	10.56		
Region C	10.48	17.11		
Region D	6.04	8.41		
Region E	10.05	14.89		
Region F	13.75	16.29		
Region G	8.33	11.45		
Region H	2.84	9.87		
Region I	4.96	6.08		

Inpatient Psychiatric Average Length of Stay				
	Greater than 10	7 -10	Less than 7	
	Previous Quarter	Q3 2015	Progress	
Aggregate	10.49	9.17		
Region A	6.80	6.67		
Region B	8.70	8.20		
Region C	7.75	7.00		
Region D	4.00	6.67		
Region E	5.75	7.67		
Region F	9.75	11.20		
Region G	36.50	20.33		
Region H	7.00	7.33		
Region I	12.00	13.00		

IP Psych Hosp Readmit Rate				
	Greater than 16%	16% - 8%	Less than 8%	
	Previous Quarter	Q3 2015	Progress	
Aggregate	23.3%	22.2%		
Region A	16.7%	22.2%		
Region B	10.0%	11.1%		
Region C	40.0%	22.2%		
Region D	50.0%	55.6%		
Region E	0.0%	0.0%		
Region F	50.0%	40.0%		
Region G	0.0%	0.0%		
Region H	0.0%	14.3%		
Region I	25.0%	20.0%		

Number of Admits to PRTF per 1000				
	Greater than 3	1-3	Less than 1	
	Previous Quarter	Q3 2015	Progress	
Aggregate	1.50	1.44		
Region A	0.00	0.00		
Region B	2.39	1.17		
Region C	4.19	1.90		
Region D	1.01	0.93		
Region E	2.51	2.13		
Region F	0.00	0.00		
Region G	0.00	0.00		
Region H	1.42	2.82		
Region I	1.24	2.43		

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PRTF Average Length of Stay				
Greater than 10	7 -10	Less than 7		
	Previous Quarter	Q3 2015	Progress	
Aggregate	72.00	59.00		
Region A	0.00	0.00		
Region B	0.00	0.00		
Region C	0.00	0.00		
Region D	0.00	0.00		
Region E	0.00	0.00		
Region F	0.00	0.00		
Region G	0.00	0.00		
Region H	0.00	0.00		
Region I	72.00	59.00		

PRTF Readmit Rate				
Greater than 14%	14% -6%	Less than 6%		
	Previous Quarter	Q3 2015	Progress	
Aggregate	0.0%	0.0%		
Region A	0.0%	0.0%		
Region B	0.0%	0.0%		
Region C	0.0%	0.0%		
Region D	0.0%	0.0%		
Region E	0.0%	0.0%		
Region F	0.0%	0.0%		
Region G	0.0%	0.0%		
Region H	0.0%	0.0%		
Region I	0.0%	0.0%		

Number of Admits to All Out of Home Placements per 1000				
Greater than 40	20 -40	Less than 20		
	Previous Quarter	Q3 2015	Progress	
Aggregate	13.54	16.34		
Region A	17.51	23.51		
Region B	15.53	14.08		
Region C	14.68	20.91		
Region D	13.08	14.02		
Region E	22.61	23.40		
Region F	17.18	26.06		
Region G	16.67	15.27		
Region H	8.53	14.10		
Region I	6.20	8.51		

Out of Home Placement Average Length of Stay				
Greater than 10	7 -10	Less than 7		
	Previous Quarter	Q3 2015	Progress	
Aggregate	20.32	13.76		
Region A	18.60	12.83		
Region B	9.83	7.64		
Region C	19.20	7.00		
Region D	30.46	16.27		
Region E	13.89	10.75		
Region F	19.80	11.20		
Region G	28.33	20.57		
Region H	26.67	20.25		
Region I	22.00	22.20		

Out of Home Placement Readmit Rate				
Greater than 20%	20% - 12%	Less than 12%		
	Previous Quarter	Q3 2015	Progress	
Aggregate	20.8%	18.7%		
Region A	10.0%	30.8%		
Region B	7.7%	8.3%		
Region C	28.6%	18.2%		
Region D	30.8%	33.3%		
Region E	33.3%	9.1%		
Region F	40.0%	25.0%		
Region G	25.0%	0.0%		
Region H	0.0%	10.0%		
Region I	20.0%	14.3%		

**Network Development and Highlights**

Network development has remained critical to the success of CSoc. The expansion of the CSoc program on 11/20/2014 included 4 new regions and successfully launched the program statewide. This network growth expanded the 5 specialized 1915(c) HCBS waiver services statewide as well.

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The following chart shows data up to December 2015 and shows the current number of providers for each region by type. It should be noted that Parent and Youth Support and Treatment is provided by one statewide agency that serves each of the implementing regions. There was a 23.1% increase in the total network from March 2015 to December 2015.

CSOC Service	Crisis Stabilization	Independent Living/Skills Building	Parent Support & Training	Short Term Respite Care	Youth Support & Training	CY3 Total	CY4 Total	Change
Region 1	0	44	1	2	1	48	38	10
Region 2	0	19	1	1	1	22	14	8
Region 3	0	9	1	0	1	11	8	3
Region 4	1	5	1	1	1	9	8	1
Region 5	0	13	1	1	1	16	15	1
Region 6	0	7	1	1	1	10	11	-1
Region 7	0	12	1	2	1	16	15	1
Region 8	0	15	1	0	1	17	14	3
Region 9	0	23	1	2	1	27	20	7
<b>TOTAL</b>	<b>1</b>	<b>147</b>	<b>9</b>	<b>10</b>	<b>9</b>	<b>176</b>	<b>143</b>	<b>33</b>

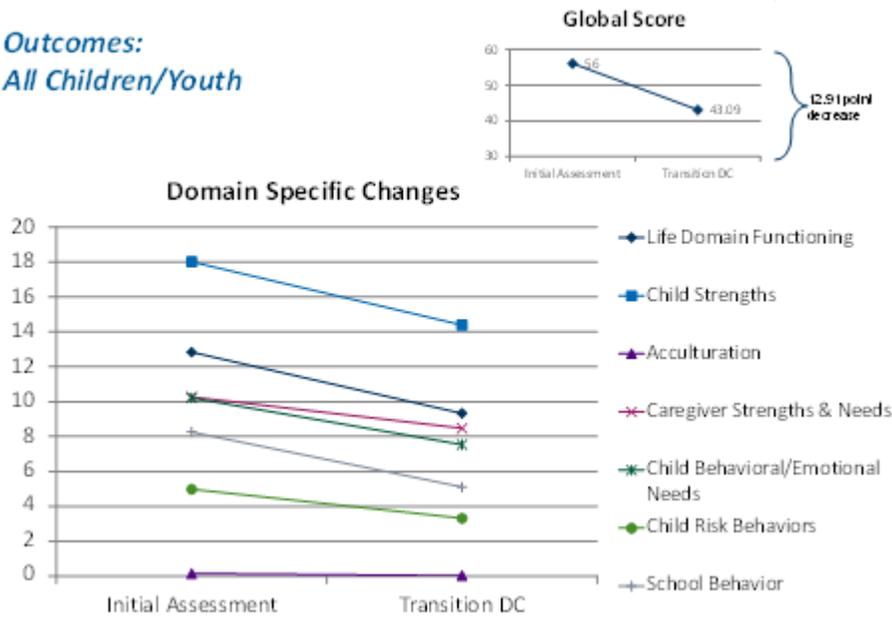
Magellan will continue to support DHH in addressing barriers to CSoc service development with the goal of ensuring that the provision of specialized behavioral health and waiver services to CSoc children/youth will occur consistent with the goals and principles of DHH. In January 2016, Magellan will submit a Network Development and Management Plan to outline our processes to develop, maintain, manage and monitor the provider network. With the integration of specialty behavioral health care services into its existing medical managed care system, the expansion of children’s residential services will transition to the Bayou Health plans. Magellan will work jointly with the Bayou Health Plans to expand crisis stabilization when the service is added to the State Plan Amendment, which would make it a service accessible to all children.

**Program Outcomes**

As outlined in Section XII Clinical/Functional Outcomes Activities, Magellan utilizes the CANS assessment tool to measure outcomes for the CSoc Program. The following section provides an analysis of CANS data showing positive outcomes for the program. The analysis includes 197 CSoc members with a paired initial and discharge CANS submitted electronically from 6/1/15 – 8/31/15. The Global Score, which is a SUM of all items scores, and the Domain Level scores, were used in this analysis. All CSoc members with a paired initial and discharge CANS submitted (n = 197) are included.

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*Outcomes:*  
*All Children/Youth*



- Global Score change from Initial → discharge = 12.91
  - Indicates statistically significant improvement (p < .001).
- Domain scores all decreased and continue in the desired direction
  - Indicates statistically significant improvement (p < .001 to .05 values).

Please see Section **XII Clinical/Functional Outcomes Activities** for complete CANS outcomes data for program.

Another mechanism to measure outcomes is the reason for discharge from the program. There were 349 discharges during 2015 Q4, 40.97% of those discharged had a “successful” discharge, meaning they met 75-100% of their identified goals. This is 3.47 percentage points higher than last quarter or a 9.25% increase.

Reason for Discharge	Count	% of CSoc discharges	% of CSoc pop
Successful discharge – (75-100% of identified goals were met)	143	40.97%	5.22%
Legal guardian choose to discontinue CSoc	45	12.89%	1.64%
Child/family disengaged from services	39	11.71%	1.42%
Relocation	32	9.17%	1.17%
Residential placement	26	7.45%	0.95%
Good discharge – (50-75% of identified goals were met)	24	6.88%	0.88%
Other	17	4.87%	0.62%
Child/family cannot be found	14	4.01%	0.51%

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Fair Discharge – (25-50% of identified goals were met)	6	1.72%	0.22%
Child choose to discontinue CSoc	3	0.85%	0.11%
Discharged Totals:	349	100.00%	12.75%

The utilization of natural and informal supports following discharge increases likelihood that gains made while in the program will be sustained. The utilization rate for natural and informal supports is reported by the Wraparound agencies. There was a 4.59 % increase of members utilizing natural and informal supports during CSoc enrollment to after their discharge during Q4 2015.

- Percent of CSoc children and youth who reportedly utilized natural and informal supports during enrollment = 88.53% (or 2,423/2,737 unique members enrolled)\*
- Percent of CSoc children and youth who reportedly utilized natural and informal supports after discharge = 93.12% (or 325/349 unique members who had been discharged)\*

Another tenet of the program is to show decreases in restrictive placements following enrollment. There has been a 13.80% reduction (839 with OOH during WAA/1507 with OOH before WAA) in restrictive placements since enrollment in the program. Percentages are based on 6412 total enrollment since March 2012.

- Percent of CSoc children and youth who had restrictive placements prior to enrollment in WAA: **31.12%**
- Percent of CSoc children and youth place in restrictive placement after enrolling in WAA = **17.32%**

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**Next Steps**

Beginning in December 2015, Magellan will serve as the as a Prepaid Inpatient Health Plan (PIHP) healthcare delivery system responsible for the administration and management of specialized behavioral health for children and youth referred to and/or enrolled in the CSoc Program. The following objectives will guide the UM/QM program:

- Maintain the CSoc for children/youth and their families/caregivers, utilizing a family and youth-driven practice model, providing wraparound facilitation by child and family teams that also utilize family and youth supports, and overall management of these services by the Contractor.
- Continue to advance resiliency, recovery, and consumer-focused system of person-centered care.
- Reduce the rate of avoidable hospital stays and readmissions.
- Improve access, quality, and efficiency of specialized behavioral health services for children and youth through management of these services.
- Coordinate seamlessly specialized behavioral health services with the Bayou Health Contractor responsible for member’s specialized behavioral and physical health services.
- Implement best evidence-based and informed practices that are effective and efficient as supported by the data from measuring outcomes, quality and accountability.
- Increase patient quality of care: outcomes, access, and member experience of care.
- Increase member and family personal responsibility and self-management.
- Decrease fraud, abuse, and wasteful spending.

**XVIII. Member, Family Member and Stakeholder Involvement**

A true “culture of quality” must be based on a solid QM strategy that is informed by an organization’s Members and stakeholders. The design, implementation and evaluation processes must be a product of extensive local review and feedback. The Louisiana Unit actively recruits members, families, caregivers, providers, advocates, and local stakeholders to serve as members on all of its quality committees. Feedback from these individuals affords the committees unique firsthand experiences while adding depth and understanding to the evaluation process. These individuals help Magellan committees identify and prioritize relevant information and ideas worthy of further design and pursuit. Stakeholder input helps the committee evaluate and understand quality findings and identify root causes that otherwise may not have been considered.

**A. Communication with Members and Family Members**

The Louisiana Unit is dedicated to the exchange of information to our members and family members through the quality committee structure. The Member Services Committee (MSC) and the Family, Member, Advocate, and Stakeholder Committee (FMASC) provided a mechanism for member/family member involvement. Magellan also has active involvement of a member and family member

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representative on the Magellan Governance Board. The committees reviewed and provided feedback related to:

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

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

- **Web-based Education and Support Resources.** Our MagellanofLouisiana.com website is designed for members, providers and other stakeholders and provides access to a comprehensive health and wellness library, as well as access to our comprehensive E-Learning Center that includes resources such as health literacy materials encouraging healthy living, our Peer Support Whole Health and Wellness e-newsletter archive, the opportunity to take e-courses on resiliency and recovery and peer support and other useful information. Members can search for providers through our LBHP customized provider search function.
- **Autism Resources.** Magellan provides resources exclusively for caregivers of children with autism, including access to [www.MyAutismTeam.com](http://www.MyAutismTeam.com), a social network and support group, and [www.LoveMyProvider.com](http://www.LoveMyProvider.com), a searchable directory of services and providers recommended by other caregivers. In Louisiana, we posted these resources on our website and promoted them through our community e-newsletter.

## **B. Communication with Providers and Stakeholders**

Provider and stakeholder involvement are also key components of the quality committee structure and provides a mechanism to communicate important information regarding operational and quality initiatives. Providers and stakeholders serve as standing members on quality subcommittees (e.g.,

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Regional Network Credentialing Committee, MSC, FMASC, REC, etc.) and the Magellan Governance Board. Providers and stakeholders reviewed and provided feedback for the following:

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

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

Training Type	Specifics
<b>Dedicated Louisiana Provider Relations Liaison Supports Provider Training</b>	Magellan has a dedicated Provider Relations Liaison (PRL) focused on meeting the training needs of Louisiana providers. Training activities are guided by our Louisiana specific provider training plan as well as the CSOC training plan and delivers ongoing training programs to all providers. The PRL is also available to design and deliver training based on the specific needs of and requests from providers. Support includes face-to-to face or webinar delivery of training programs.
<b>New Provider Orientation</b>	Following the initial orientation sessions, we will determine, in conjunction with DHH-OBH leadership, the need for additional orientation. Throughout the contract term we will offer training opportunities that will benefit the overall delivery system. Some of the topics covered in our new provider orientation session include: an introduction to the LBHP, verification of member eligibility, claims submission and claims resolution, authorization and claims reports, the Louisiana Dashboard, MP.com, CA, provider search on Magellan’s Louisiana website.
<b>Regular Provider Meetings</b>	On the third Thursday of each month Magellan hosts an all-provider call. This conference call allows Magellan to conduct focused training and share information with the Louisiana provider community. Each meeting has an agenda which is shared in advance with providers on our website. Each meeting allows for a provider question and answer period. Prior to each meeting, providers have the opportunity to submit agenda topics using their assigned PRL, e-mail, or our website. Material from these meetings is posted to our website so that providers always have easy access

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Training Type	Specifics
	for future reference.
<b>Ongoing Technical Assistance</b>	Technical assistance needs are identified during day-to-day contact with providers, and technical assistance can be conducted with individual providers or through provider forums, newsletters, mailings, online tutorials, or electronic provider notices. Our Louisiana network team works in the community and provides an ongoing communication link with all providers. Providers are also supported by the Louisiana based staff. Providers have access to Magellan staff members knowledgeable in the Louisiana program 24/7/365. The Network Strategy Committee (NSC) also serves as a communication vehicle between the provider community and the larger LBHP program.
<b>Provider Site Visits</b>	Magellan PRLs visit providers at regular intervals, address operational issues, and make sure that communication lines remain open
<b>E-learning – Relias Essential</b>	Magellan offers e-learning courses to providers through our partnership with online training resource, Relias. Providers view this as a valuable service, particularly for those in rural areas who have difficulty attending workshops or conferences in person. There are nearly 500 courses to choose from including courses in addiction, developmental disabilities, computer skills, children services, and many other areas. There are also video workshops and conferences. Providers obtain continuing education credit for each course they take and as a Magellan network provider this service is offered at no charge. Providers currently have access to Magellan’s Achieve application for certification training.
<b>Provider Handbook</b>	Magellan’s DHH-OBH approved provider handbook is available on the provider website. Printed copies of the handbook are available for distribution upon request.
<b>E-mail Blast Notifications</b>	Magellan uses e-mail blast technology to communicate information to the Louisiana provider community for general notification updates, upcoming training events, and other important information as appropriate. Examples of recent e-mail blasts include the fax process for authorizations, CPT code changes, provider rate changes, and Case Logix announcement.
<b>Provider Newsletter – Provider Focus</b>	In addition to a monthly provider newsletter specific to LBHP, Louisiana providers have access to <i>Provider Focus</i> , Magellan’s national quarterly provider newsletter. The newsletter includes articles by clinical professionals covering both mental health and substance use topics. The newsletters are posted to Magellan’s Louisiana website.

**C. Communication with Louisiana Behavioral Health Partnership (LBHP)**

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

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

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**XIX. Satisfaction Surveys and Grievances**

**A. Member Experience of Care Survey**

The member satisfaction survey is a key component of our quality program. Member satisfaction surveys remain the most direct measure of assessing the member's perceptions of quality and outcome of care. Gathering Member input and feedback allows us to continuously improve our processes to become more effective as well as to learn the needs of those we serve in order to improve the member experience of care. The Louisiana Unit utilizes the Magellan Member Experience of Care survey to measure satisfaction. The survey, based on the Mental Health Statistics Improvement Program (MHSIP) Consumer survey, was modified for the public sector to promote consistency with surveys administered company-wide for the Medicaid population. Youth and adult versions are used to address the unique needs of the each population subset. The survey responses are based on a balanced scale with a neutral middle for most questions.

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

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

In 2015, all clients who requested treatment between (03/01/2015 - 03/31/2015) who had not been surveyed during the previous twelve months were selected for the sample. To meet the acceptable statistical requirements for a Power of .80 and a precision level of 95% confidence interval with a margin of error of +/- 5 percent, at least 385 respondents were needed. An assumption of approximate 15 percent response rate was also used to complete the calculation of the sample. The response rate for the contract year four administration was 14.3% (n=652), which was a slight improvement from the contract year three response rate of 13.0% (n=573). The 2015 response rate met the statistical requirements for a valid sample size.

Data for the survey were collected using a mail-out and mail-back. The first mailing (04/23/2015) included the cover letter prepackaged with the client satisfaction questionnaire, and a business reply envelope. Approximately 21 days after the first mailing, a second mailing (05/13/2015, 05/15/2015) with a follow-up letter along with another client satisfaction questionnaire and a business reply envelope was sent to those clients who had not yet responded with a completed questionnaire or by means of returned mail. The survey response period was closed approximately 30 days after the

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second mailing (06/05/2015). Results were calculated and analyzed by the Magellan national survey department to ensure statistical validity and reliability of the results. The following chart outlines a sample of questions with comparison to the contract year three administration.

**Magellan Member Experience of Care (Combined Adult and Minor)**

	CY3		CY4		
	Number of Responses	% Positive	Number of Responses	% Positive	# N/A
If you contacted Magellan, how satisfied are you with the help you got to connect with the services you needed?	508	81.7	540	81.8	144
I like the services that I received from my provider(s)	567	85.4	608	87.4	15
If I had other choices, I would still get services from this provider(s).	567	81.2	604	84.0	33
I would recommend this provider(s) to a friend or family member.	567	83.4	605	88.1	25
The location of services was convenient (parking, public transportation, distance, etc.)	565	81.7	601	84.3	34
Staff was willing to see me as often as I felt was necessary.	566	85.7	608	83.9	22
Staff returned my call(s) in 24 hours.	567	81.0	608	82.4	39
Services were available at times that were good for me.	564	83.5	608	86.1	12
The time I waited between appointments was acceptable.	563	80.3	608	85.1	18
I was able to get all the services I thought I needed.	556	80.7	602	82.4	16
I was able to see a psychiatrist when I wanted to.	560	74.5	601	75.6	49
I felt comfortable asking questions about my treatment and medication.	563	88.7	608	88.2	22
I felt free to complain	562	81.1	606	81.9	21
I was given information about my rights.	560	87.9	597	89.5	26
Staff members were sensitive to my cultural background (race, religion, language, customs, etc)	565	85.1	604	84.9	47
My cultural preferences and race/ethnic background were included in planning services I received.	552	74.2	600	72.6	107
Staff members believe that I can grow, change and recover.	566	83.7	605	85.3	54
Staff members told me what side effects to watch out for.	558	80.2	605	80.3	53
Staff members respected my wishes about who was and who was not given information about my treatment.	559	90.6	580	91.6	21
I, not a staff member, decided what my treatment goals should be.	550	75.8	575	80.1	40

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	CY3		CY4		
	Number of Responses	% Positive	Number of Responses	% Positive	# N/A
Staff members helped me get the information I needed so I could take charge of managing my illness.	556	<b>80.9</b>	577	<b>85.3</b>	25
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	555	<b>72.3</b>	575	<b>72.2</b>	89
I deal more effectively with daily problems.	548	<b>65.6</b>	566	<b>70.1</b>	19
I am better able to deal with crisis.	550	<b>56.7</b>	560	<b>59.4</b>	26
I am getting along better with family.	551	<b>61.3</b>	558	<b>68.0</b>	17
I am more comfortable in social situations.	546	<b>57.6</b>	558	<b>57.4</b>	18
I do better in school and/or work.	532	<b>53.7</b>	542	<b>56.7</b>	105
My symptoms are not bothering me as much.	546	<b>51.2</b>	563	<b>55.6</b>	27
Overall, my satisfaction with the services and treatment I received.	533	<b>83.1</b>	535	<b>87.5</b>	

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

**Item Analysis**  
**Statistically Significant Improvement**

Question	% POSITIVE		
	CY3	CY4	p-value
I would recommend this provider(s) to a friend or family member.	83.4	88.1	<b>0.025</b>
The time I waited between appointments was acceptable.	80.3	85.1	<b>0.031</b>
I am getting along better with family.	61.3	68.0	<b>0.021</b>
Overall, my satisfaction with the services and treatment I received was:	83.1	87.5	<b>0.044</b>

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Four elements showed statistically significant improvements between CY3 and CY4 administrations, including one element that was previously identified as an opportunity for improvement in CY3 (Q29). Raw data responses are categorized as positive or not positive, and the difference in the proportion of positive responses for each question is evaluated by Pearson’s chi-square statistic. A statistically significant result for the chi-square test (p-value less than the significance threshold,  $\alpha = 0.05$ ) indicates that there is significant difference of positive response between years.

**Opportunities for Improvement**

Question	CY3	CY4								
	% Positive	Number of Responses	% Positive	% Positive and Neutral	% Strongly Agree	% Agree	% I am Neutral	% Disagree	% Strongly Disagree	# N/A or Does Not Apply
I was able to see a psychiatrist when I wanted to.	74.5	601	75.6	88.1	41.7	33.9	12.5	7.4	4.5	49
My cultural preferences and race/ethnic background were included in planning services I received.	74.2	600	72.6	92.5	38.5	34.1	19.9	5.7	1.8	107
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	72.3	575	72.2	87.2	40.7	31.5	15	9.7	3.1	89
I deal more effectively with daily problems.	65.6	566	70.1	87.7	28.2	41.9	17.6	9.7	2.7	19
I am better able to deal with crisis.	56.7	560	59.4	80.7	20.8	38.6	21.3	13.3	6.0	26
I am getting along better with family.	61.3	558	68.0	87.8	25.1	42.9	19.8	8.9	3.3	17
I am more comfortable in social situations.	57.6	558	57.4	80.5	21.5	35.9	23.1	13.5	5.9	18
I do better in school and/or work.	53.7	542	56.7	81.2	23.1	33.6	24.5	11.0	7.8	105
My symptoms are not bothering me as much.	51.2	563	55.6	77.1	21.1	34.5	21.5	15.3	7.6	27

Magellan sets an internal corporate goal of achieving at least 80% satisfaction for each element. There were 10 elements that fell below the threshold in CY3. In CY4, 9 elements did not meet the goal of 80% satisfaction. It is important to note only one element was under the 80% goal when evaluating the percent of those responding in a positive or neutral manner (Q32). There were improvements in six of the elements from the CY3 to CY4 administrations, with Q29 showing statistically significant improvement. Of the three elements that did not show improvement, there was only a decrease of two percentage points or less between the administrations. Magellan implemented a treatment planning training in June 2015 to target all the opportunities for improvement except Q13. The training was focused on member involvement in the initial treatment planning process to ensure member needs are addressed as well as improving ongoing member involvement in the treatment planning process in order to monitor members’ perception of progress and address barriers to treatment in real time. Q13 evaluates members’ perception of seeing a psychiatrist when needed. Magellan will implement ad hoc contracting interventions to monitor and address access issues regarding psychiatrist availability.

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Please see the following Member Satisfaction Action Plan for detailed list of interventions for each element identified as an opportunity for improvement. It should be noted that the majority of elements that fell below 80% involved the members’ perceptions of how their symptoms have improved.

Item	Discussion	Action	Responsible Party	Due Date
<b>Q18 My cultural preferences and race/ethnic background were included in planning services I received.</b>	This element did not meet the threshold goal of 80% or above. There was 92.5% satisfaction for this element when evaluating positive and neutral responses. There was also a large number of members (n=107) citing this element was not applicable to them. Workgroup acknowledge the importance of this issue, especially as related to the Medicaid population. Magellan conducted annual population assessment and cultural competency plan to guide the program around cultural needs of the state. Magellan discussed the importance of promoting patient centered treatment planning that address member’s perception of care and outcomes.	Results will be disseminated to the Governance Board and QIC.	Wendy Bowlin/ QM Admin.	May 2015; Completed
		Implement Cultural Competency Plan for 2015	Kathy Coenson/VP of System Transformation	March 2015; Completed
		Magellan conducted a training module on person centered treatment planning to increase provider awareness of the addressing cultural preferences in treatment planning that will be disseminated to all providers.	Wendy Bowlin/ QM Admin.	June 2015; Completed
		Link to Training: <a href="http://www.magellanoflouisiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf">http://www.magellanoflouisiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf</a>		
	Monitor compliance that cultural preferences were assessed through the TRR monitoring process.	Dawn Foster, QI Manger	Ongoing until 09/2015; Completed	

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Item	Discussion	Action	Responsible Party	Due Date
<p><b>Q13 I was able to see a psychiatrist when I wanted to</b></p>	<p>There was a slight increase in this measure from CY3 rate of 74.5%. There was 88.1% satisfaction for this element when evaluating positive and neutral responses. Although Magellan has seen an increase in the number of prescribers in the network, access to psychiatrist is an issue for both public and commercial sectors. Magellan is currently at 100% compliance for geoaccess standards for urban areas and at 99% compliance for rural areas. Magellan will continue to track member grievances related to accessing psychiatrist and will create ad hoc agreements with prescribers if no contracted prescribers are available to the member.</p>	<p>Member Service Representatives will assist members who are unable to access a prescriber when a member request is made.</p> <p>Analyze network composition regularly through review of ad hoc reporting. Recruitment efforts will be initiated in areas where frequent ad hocs are completed due to lack of network availability.</p> <p>Any time our ad hoc agreements increase by more than 25% within Louisiana or there is a significant increased trend in ad hoc agreements over a 2 month time period, Magellan will initiate recruitment activities.</p> <p>If there are multiple ad hocs agreements for a specific provider, Magellan will reach out to attempt to recruit the provider.</p>	<p>Latishia Anderson, MS Administrator</p> <p>Gail Fowler, Network Administrator</p> <p>Gail Fowler, Network Administrator</p> <p>Gail Fowler, Network Administrator</p>	<p>Continuous and Ongoing; Completed</p> <p>June 2015, Completed</p> <p>June 2015; Completed</p> <p>June 2015, as needed</p>

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Item	Discussion	Action	Responsible Party	Due Date
Q 25 I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	Threshold goal of 80% or above was not met for CY4. There was 87.2% satisfaction for this element when evaluating positive and neutral responses. Magellan discussed that the utilization of consumer-run programs and natural supports are essential for increasing community tenure. Magellan will focus training efforts to improve provide awareness of including natural supports as part of the treatment planning process.	Results will be disseminated to the Governance Board and QIC.  Magellan will develop a training module on person centered treatment planning to increase provider awareness of the member involvement in treatment planning that will be disseminated to all providers.  Link to Training: <a href="http://www.magellanoflouisiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf">http://www.magellanoflouisiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf</a>  Monitor compliance of the use of natural supports through waiver monitoring. Providers that are not in compliance will be required to complete a Corrective Action Plan on addressing deficiencies.	Wendy Bowlin/ QM Admin.  Wendy Bowlin/ QM Admin.  Dawn Foster, QI Manager; Donna Herren, CSoC Reporting Manager	July 2015; Completed  June 2015; Completed  Ongoing until 09/2015; Completed
Q26 I deal more effectively with daily problems.	Elements based on member perception of outcomes were lower than established threshold. When evaluating positive and neutral responses, only Q32 was below the 80% threshold. Four of the five elements showed improvements from the CY3 to CY4 administrations, with Q29 showing statistically significant improvement.  Workgroup discussed that member perception regarding outcomes is consistently low across the public sector populations. Factors, such as impactability and readiness for treatment can greatly affect member perception of outcomes. This is a chronic population with more barriers to improvement. It was also noted that where a member is in their treatment process will also	Results will be disseminated to the Governance Board and QIC.	Wendy Bowlin/ QM Admin.	May 2015; Completed
Q28 I am better able to deal with crisis.		Magellan will develop a training module on person centered treatment planning to increase provider awareness of the member involvement in treatment planning that will be disseminated to all providers.	Wendy Bowlin/ QM Admin.	June 2015; Completed
Q29 I am getting along better with family.				
Q30 I am more comfortable in social situations.				
Q31 I do better in school and/or work.			Link to Training: <a href="http://www.magellanoflouisiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf">http://www.magellanoflouisiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf</a>	

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Item	Discussion	Action	Responsible Party	Due Date
Q32 My symptoms are not bothering me as much.	<p>inform the level of satisfaction with the care provided. It was noted that providers have the best opportunity to shape and track member’s perception of their outcomes.</p> <p>It is believed that the IA/CBCM and Wrap Around model could positively impact awareness of members for those eligible through the 1915(i) SPA and the 1915(c) and (b3) waivers.</p>	<p><a href="http://lsiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf">lsiana.com/media/1221560/treatment_plan_development_provider_training_06_18_2015.pdf</a></p> <p>Monitor compliance with member involvement in treatment planning through TRR and waiver monitoring. Providers that are not in compliance with waiver performance measures will be required to complete a Corrective Action Plan on addressing deficiencies.</p>	Dawn Foster, QI Manager; Donna Herren, CSoc Reporting Manager	Ongoing until 09/2015; Completed

**B. Member and Provider Grievances**

Magellan’s priority is to ensure members have a “no wrong door” approach to filing a grievance and that the process is streamlined and as easy as possible for the Member to navigate. That starts with ensuring Members, providers and other LBHP stakeholders are informed of grievance and appeal rights and processes. These processes are detailed in the Member and provider handbooks, are available online at [www.MagellanofLouisiana.com](http://www.MagellanofLouisiana.com), and are available in Spanish and Vietnamese (and can be made available in other languages upon request).

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

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

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All grievances are documented into Magellan’s web-based Comment and Resolution Tracking (CART) system for quality management purposes. We send an acknowledgement to the individual within three business days and member grievances are resolved within the contractual timeframe of 30 calendar days. Provider grievances are resolved within Magellan’s corporate standard of 30 calendar days. Because of the unique and vulnerable nature of the populations served by the 1915(c) and 1915(b)3 waivers, as well as the 1915(i) State Plan Amendment, grievances filed for those Members are resolved within 14 calendar days, as are quality of care concerns. Magellan conducts quarterly audits on a sample of the grievance files to ensure that staff is following the established policies and procedures, correct letters are being used, and that files are compliant with all accreditation standards.

Magellan uses the data generated by the grievance management system to identify and address any trends or patterns in use or misuse of services, such as a disproportionate number of an individual type of grievance or a high or increasing number of grievances related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the appropriate committee conducts a root cause analysis and recommends interventions. This information allows the QIC to quickly identify where to focus improvement efforts as well as implement program enhancements to increase the individual’s ability to obtain needed services and achieve optimal treatment outcomes. We review this information continuously, so improvements to the system can be made on an ongoing basis. Individual grievance data, while maintained to manage the process of resolution and response, is not used in reporting or committee to protect Member privacy. If the Grievance Coordinator notes more than three grievances for the same provider, the issue is escalated to the QM team and reported to the Regional Network Credentialing Committee.

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

### **Member Grievances**

The Louisiana Unit received 88 member grievances during contract year four. The average resolution time for member grievances was 19 days. The top three grievances types are outlined in the below chart.

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<b>Comment Reason</b>	<b>Comment Subreason</b>	<b>Total</b>
Quality of Service/Provider	Unsatisfactory treatment experience	19
Quality of Service/Provider	Provider attitude/unprofessional behavior	18
Quality of Care	Care not appropriate	9

**Provider Grievances**

The Louisiana Unit received 37 provider grievances during contract year four. The average resolution time for member grievances was 21 days. The top three grievances types are outlined in the below chart.

<b>Comment Reason</b>	<b>Comment Subreason</b>	<b>Total</b>
Potential Quality Issue	Possible ethical violation	3
Quality of Service/Magellan	Magellan staff attitude/unprofessional behavior	3
Other - BARRIERS	Other - CONTINUITY OF CARE	2

**XX. Appeals Analysis**

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

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From March 1, 2015 to November 30, 2015, a total of 926 appeals (721 standard appeals and 205 expedited appeals) were filed. Of the member appeals, 492(68%) of the initial determinations were upheld, 53 (6%) were partially reversed, and 48 (5%) were reversed. In addition, 333 (36%) were withdrawn by the submitter. Appeals are considered withdrawn if the member’s consent is not received within 30 days of sending the provider or member a Notice of Action letter indicating the consent is needed. Ninety-nine percent (99%) of standard member appeals were resolved within the 30-day resolution timeframe, with 99% of expedited member appeals resolved within three (3) business days of the request.

Twenty (20) of these required a state fair hearing. Of those, 5 determinations were upheld, 8 were administratively overturned, 4 were withdrawn by the appellant, and 3 were withdrawn by the administrative law judge due to failure to submit timely. Eight (8) of these required an administrative hearing. Of these, three (3) were withdrawn and five (5) are pending completion of federal court hearing. The cases are considered withdrawn if the member or member representative does not respond to the request for hearing.

**XXI. Provider Site Visits**

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

The Louisiana Unit conducted 39 onsite Treatment Record Review, Waiver Performance Measure and ACT Fidelity Audits and quarterly onsite reviews of Wraparound Agencies during contract year four. Louisiana Unit QI staff reviewed record keeping and documentation standards to ensure it was complaint with quality standards. Please see Section XIV Treatment Record Reviews and Clinical Practice Guidelines and Section XVI Evidence- and Best Practice Initiatives for more information on these activities.

**XXII. Accreditation and External Review**

Magellan actively participated in both internal and external monitoring to ensure compliance with contract deliverables, federal regulations and corporate standards. The Louisiana Unit obtained full URAC Accreditation under Health Utilization Management Standards, Version 7.0 in January 2014, with an effective date through January 1, 2017. Magellan conducted internal audits for appeals, grievances,

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credentialing, and personal files to ensure compliance with URAC standards. Magellan also complied with all External Quality Review Organization (EQRO) reviews conducted during contract year four.

**XXIII. RESOURCES**

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

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

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

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

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**XIV. DELEGATION**

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

**XXV. REGULATORY COMPLIANCE MONITORING**

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

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

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

The Magellan Compliance Handbook is distributed to all employees when they begin working at Magellan, and is reviewed annually, so that employees are familiar with the ethical and legal standards with which they are required to comply. The Compliance Administrator ensures all staff members are educated on policies and where to locate these policies. In addition, all Magellan staff is educated at the time of orientation and annual URAC trainings on how to contact the Compliance Administrator. In addition, each staff member is required to complete an attestation insuring understanding of those procedures and guidelines. Links to applicable State Medicaid internet sites are also accessible through MagNet.

Providers are informed of the fraud and abuse program and practices, including the fact that allegations will be reported and investigated. This information is included in the Provider Handbook.

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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
- Molina (SURS )

Internal Sources:

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

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

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

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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 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 Health Information (PHI) is controlled according to the HIPAA Privacy and Security requirements and Magellan's confidentiality policies and procedures, as well as to identify and assess areas of potential internal risk. In addition, Non-Compliance reports of annually mandated HIPAA/Privacy and Compliance trainings are routinely monitored and tracked by the Compliance Administrator, as these trainings are designed to help foster Magellan of Louisiana employees' awareness and ensure self-compliance with federal and state requirements. Compliance with these requirements is even more essential in light of the new breach notification provisions and associated financial penalties prescribed in the HITECH Act provisions of the American Recovery and Reinvestment Act of 2009. Employee's non-compliance with these training requirements is addressed, in collaboration with Magellan's Human Resources department, using a progressive discipline approach.

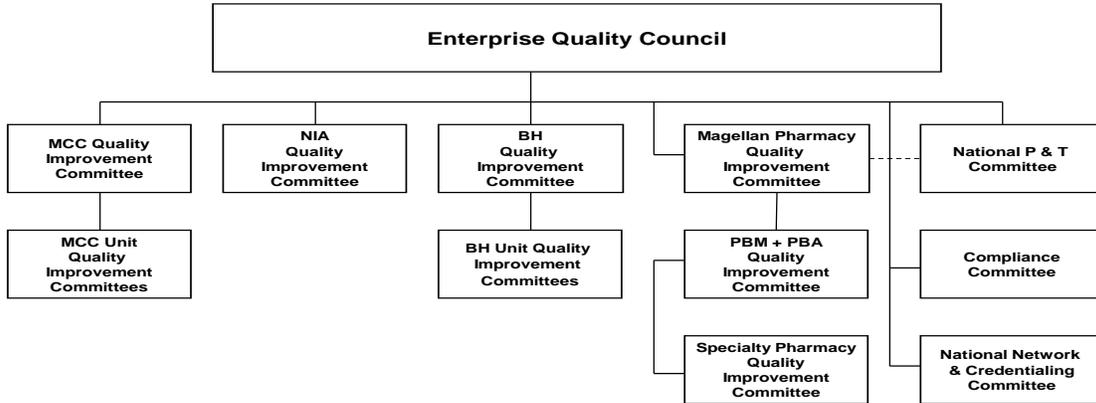
**XXVI. SUMMARY**

The contents of this report and documentation provided in the Appendices summarize Louisiana Unit's 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.

## Appendix A. MH Enterprise Committee Structure



### Quality Improvement Program Structure



11/27/13

## Louisiana Unit Quality Committee Structure

