DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP TRANSPARENCY REPORT

REPORT PREPARED IN RESPONSE TO (ACT 212) OF THE (2013) REGULAR SESSION

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Contact:
Louisiana Department of Health and Hospitals
Name: Jennifer Katzman
Office of Behavioral Health
Post Office Box 4049, Baton Rouge, LA 70821-4049

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EXECUTIVE SUMMARY

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

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

1) Implementation of CSoC;

2) Improved access, quality and efficiency of behavioral health services for children not eligible for CSoC and for adults with severe mental illness and addictive disorders;

3) Successful transition from a regional model for behavioral health care to human service districts or local governing entities (LGEs);

4) Seamless coordination of behavioral health services with the comprehensive healthcare system without losing attention to the special skills of behavioral health professionals;

5) Advancement of resiliency, recovery and a consumer-focused system of person-centered care; and

6) Implementation of best practices and evidence-based practices that are effective and supported by data collected from measuring outcomes, quality and accountability.

INTRODUCTION

The LBHP provides a new approach to both delivering and financing behavioral health services for Louisiana's children and adults through a fully integrated, single-point-of-entry system. This new service delivery model creates an integrated public behavioral health service system drawing on the strengths of the private, public and non-profit sectors. The goals are to provide enhanced access to a more complete and effective array of evidence-based behavioral health services and supports, while also improving individual health outcomes. Ultimately, by enhancing access and offering coordinated care management, the LBHP is expected to yield a reduction in unnecessary hospitalizations, institutionalizations and emergency department visits, and a higher quality of care for children, adults and their families. To achieve this goal, the LBHP made major strides to expand access to services and, in doing so has served approximately 79,000 children and 72,000 adults with serious mental illness, major mental disorder, acute stabilization needs and/or addictive disorders. This exceeds the program objective of treating at least 50,000 children, and also displays great progress toward reaching the goal of serving 100,000 adults.

Within the LBHP, the CSoC offers a comprehensive array of intensive services with the goal of enabling these children to remain in or return to their homes and communities. Wraparound Agencies (WAAs) provide individualized care planning and management through Child and Family Teams (CFTs), which are charged with the development of each child or youth's plan of care. Once CSoC is available statewide, it is anticipated that about 2,400 youth who are at greatest risk and have the most complex needs will be part of the program. At the end of the first year of operations, CSoC had been implemented in five regions of the state and served nearly 1,300 children.

All major transformations present challenges along the way. In the first year of this ambitious initiative, the LBHP confronted primarily administrative challenges regarding collection of billing, claims and clinical information data. Significant progress and improvements have been achieved in these areas. Additionally, discrepancies between the state licensing law age requirements and federal guidelines have created funding challenges related to providing substance use residential treatment those in the 18 to under 21 age population, which the State has addressed by using available block grant funds to maintain services to this population. Development of a full network of out-of-home treatment options for children and youth has not occurred as quickly as anticipated while existing organizations work to adapt their services to align with requirements and best practices for this population. Magellan continues to aggressively recruit providers and negotiate individual contracts to meet provider and network needs, and as a result, has made great strides in expanding these networks of providers. Recently, 20 new psychiatric residential treatment beds and 6 new therapeutic group home beds were added to the LBHP provider network. Magellan continues to offer technical assistance to support and assist providers with these issues as needed.

The LBHP continues to improve how we serve Louisiana citizens with behavioral health issues and offers the following measures and outcomes as part of this managed care transparency report. Since implementation, noticeable expansion of services, increased numbers of enrolled members and a dramatic expansion in the provider network have occurred. This is particularly demonstrated through the 87% increase in adult inpatient bed capacity through the Magellan network of providers. Further information regarding initiatives and expansion within the LBHP is identified through the data included in this report. For ease of reference, the information requested within Act 212 has been

divided into sections by the matching numerical request in the legislation. However, due to the complex nature of these data requests, a data book has been attached in conjunction this report to match specifically identified requests.

SECTION 1: LOCAL GOVERNING ENTITY INFORMATION

DHH Region	Local Governing Entity (LGE) Contract Information	Parishes
Region 1	Metropolitan Human Services District (MHSD) Judge Calvin Johnson, Executive Director 1010 Common, Ste. 600, New Orleans, LA 70112 504-568-3130	Orleans, St. Bernard, and Plaquemines
Region 2	Capital Area Human Services District (CAHSD) Jan Kasofsky, Ph.D., Executive Director 4615 Government Street Baton Rouge, LA 70806 225-922-2700	Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciana
Region 3	South Central Louisiana Human Services Authority (SCLHSA) Lisa Schilling, Executive Director 521 Legion Avenue Houma, Louisiana 70364 985-858-2931	Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne
Region 4	Acadiana Human Services District (AAHSD) Brad Farmer, Executive Director 302 Dulles Drive Lafayette, LA 70506 337-262-4190	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin and Vermilion
Region 5	Imperial Calcasieu Human Services Authority (ImCal) Tanya McGee, Executive Director 3505 5th Avenue, Suite B Lake Charles, LA 70607 337-475-3100	Allen, Beauregard, Calcasieu, Jefferson Davis and Cameron
Region 6	Central Louisiana Human Services District (CLSHD) Egan Jones, Executive Director 401 Rainbow Drive, Unit 35 Pineville, LA 71360 318-487-5191	Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon and Winn
Region 7	Northwest Louisiana Human Services District (NLHSD) Doug Efferson, Executive Director 2924 Knight Street, Suite 350 Shreveport, LA 71105 318-862-3085	Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster
Region 8	Northeast Delta Human Services Authority (NEDHSA) Monteic Sizer, Ph.D., Executive Director 2513 Ferrand St. Monroe, LA 71201 318-362-3270	Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union and West Carroll

Region 9	Florida Parishes Human Services Authority (FPHSA) Melanie Watkins, Executive Director 835-B Pride Drive, Hammond, LA 70401 Phone# 985-748-2220	Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington
Region 10	Jefferson Parish Human Services Authority (JPHSA) Lisa English Rhoden, Executive Director 3616 South I-10 Service Road West, Metairie, LA 70001 504-838-5215	Jefferson

SECTION 2: PROVIDER INFORMATION

In the past year, the Office of Behavioral Health (OBH) and its contractor Magellan have overseen the expansion of the network of providers available to deliver behavioral health care from approximately 800 to 1,700 providers across the state. This provider number is defined by entry point, so a provider is identified by each location it services. This expansion in the provider network includes additional provider types and additional services, including services allowable within the scope of practice and professional license of Licensed Mental Health Professionals, 24-7 crisis triage by telephone, mobile services, community psychiatric support and treatment, psychosocial rehabilitation, additional evidence-based practices, addiction rehabilitation, and case conference services, which are scheduled face-to-face meetings between two or more individuals to discuss the beneficiary's treatment. The 1,700 providers combined provide a total of almost 5,000 specialties of service. *A comprehensive list of providers enrolled in the Magellan network, along with their specialties, credentialing status, and provider type can be found within the attached data book on the second tab labeled* ***"#2 All Providers."***

SECTIONS 3 – 8: MEMBER/ENROLLEE INFORMATION

Approximately 1 million individuals have become enrolled members of Magellan's health plan. These members now have access to information, education and new services. Details of the following legislative requests can be found in the attached data book on tabs 3 through 8 as follows:

Legislative Request Item Number:	Data Book Tab Label:
SECTION 3: Members by Parish	#3 Medicaid & Non-Medicaid
SECTION 4: Adult Medicaid Enrollees	#4 Adult Medicaid Enrollees
SECTION 5: Adult Non-Medicaid Enrollees	#5 Adult Non-Medicaid Enrollees
SECTION 6: CSoC Children Receiving Services	#6 CSoC Enrollees
SECTION 7: Non-CSoC, Medicaid Children Receiving Services	#7 Non-CSoC Medicaid Youth
SECTION 8: Non-CSoC, Non-Medicaid Children Receiving Services	#8 Non-CSoC Non-Medicaid Youth

SECTION 9: PERCENTAGE OF CALLS REFERRED TO SERVICES

This data element shows the number of calls received by Magellan from clients that identified their parish of residence, and also the number and percentage of those calls referred for services. Parishes with the highest number of calls in descending order include East Baton Rouge, Orleans, Jefferson, Caddo, Ouachita, Rapides, Calcasieu, and Lafayette. Clients call Magellan for various reasons and do not always require referral to services, particularly if the call is solely for the purpose of requesting or

gathering information. Clients are referred to services upon request and based on an assessment of their behavioral health needs. Persons not requiring referral to services may decide to remain anonymous, which accounts for the number of calls that remain unidentified by parish. Of the callers identified with a parish, on average, 67% were referred to services. *Please refer to the data book tab labeled "#9 % Calls by Parish" for data details.*

SECTION 10: AVERAGE HOURS FROM CALL TO AUTHORIZATION

As indicated in the previous data element, though a majority of calls are referred to services, a large minority often do not require a referral. As a result, this metric was impossible to track with accuracy. Instead, provided below is the length of time from the call to authorization of services by Magellan. According to the SMO Request for Proposal (RFP) language, the SMO generally shall provide notice of standard authorization decisions within fourteen (14) calendar days following the request for service.

Level of Care	Expedited Average Hours from Call to Authorization	Standard Average Hours from Call to Authorization
INPATIENT	1.726	4.633
OUTPATIENT	3.762	5.973

SECTION 11: PERCENTAGE OF REFERRALS CONSIDERED IMMEDIATE, URGENT AND ROUTINE

Magellan makes referrals based on the behavioral health needs of the client when presenting, either in person or by calling Magellan. Referral for services are classified as either a life-threatening emergency requiring immediate attention, an urgent need, which is generally when a member could face severe harm or pain if not expediently linked to services through urgent care, or a routine behavioral health service need. Upon referral, Magellan authorizes services based on the necessary clinical criteria. *Please refer to the data book tab labeled "#11 % by Referral Type" for the requested data details of this section.*

SECTIONS 12: CLEAN CLAIMS

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

The requested data includes the percentage of clean claims paid within 30 days for each facility broken out by Local Governing Entity (LGE). Also included in this data element is the average number of days to pay clean claims and the average number of days to pay all claims at each facility by LGE. *For this information, please refer to the tab labeled "#12 Clean Claims" in the attached data book.*

SECTION 13: TOTAL CLAIMS DENIED

As of 12/1/2013, there have been 530,364 denied claims compared to 1,744,511 paid claims, which means that denials account for only 23% of all claims. There are multiple reasons a claim may be denied. Most frequently, this is due to errors in the submission process either because provider submitted duplicate claims, the member is not eligible for the service submitted for reimbursement, or from lack of documentation or prior authorization. Duplicate claims submission is the primary reason for claims denial (30%), and non-covered diagnosis (6%) and patient ineligibility (4.5%) account for another 10.5% of denied claims. The table below reflects the request in Act 212 for percentage of denied claims by specifically requested denial types. However, please note that the requested list of items below is not exhaustive of causes for claims denial.

Act 212 - LBHP Item Number	Denial Type	Denial Type Count	All Denial Count	% of All Denials
13(a)	Lack of Prior Authorization	97,636	530,364	18.41%
13(b)	Lack of Documentation	14,306	530,364	2.70%
13(c)	Non Covered Service	76,748	530,364	14.47%

SECTION 14: PERCENTAGE OF MEMBERS PROVIDING CONSENT FOR RELEASE OF INFORMATION TO COORDINATE WITH PRIMARY CARE PHYSICIAN (PCP)

Five metrics are presented to identify the percentage of members who provide consent for the release of information for the coordination of care with the member's PCP and other healthcare providers during July 1, 2012, through June 30, 2013. Included within these five metrics are four metrics captured as part of the Treatment Record Review (TRR) process for inpatient, residential substance use, outpatient and the aggregate of these three levels of care, as well as one metric that is a data report on referrals received from the Bayou Health Plans. *Please refer to the attached data book under fourteenth tab labeled "**#14 % Consent for PCP**" for the metrics associated with this legislative request.*

The inpatient and residential substance use audit tool elements only captured data on PCP coordination while the outpatient audit tool element captured data on PCP and other providers. This could explain the difference between the outpatient and other level of care compliance rates. In addition, patients receiving outpatient services versus inpatient services may have a different level of willingness to offer their consent. From January to June 2013, Magellan received 312 referrals from Bayou Health for behavioral health services. There were an additional 595 referrals from July to December 2013. As part of the referral process, the member must sign a consent form to allow Magellan to contact the member and assist in coordination of care.

As part of quality improvement activities, an interdepartmental workgroup identified barriers to coordination of care. Barriers identified included: assigned primary care physician (PCP) unknown to member, inability for providers to quickly identify PCP if unknown, providers do not coordinate care due to lack of time or unwillingness, and member refusal. Lack of a mechanism to quickly identify the member assigned PCPs was identified as the root cause to noncompliance. Generally speaking, these barriers are not unexpected and would generally be inherent to any large system transformation, as time is required to make wholesale change.

Magellan is actively coordinating with Medicaid and the Bayou Health Plans to address this issue. Medicaid is currently working on a PCP database for easy identification of member PCPs. Magellan has a collaborative relationship with the Bayou Health Plans that includes monthly meetings to discuss

barriers and interventions to improve coordination. Magellan has implemented a standardized referral work flow and form for coordination of care with the Bayou Health Plans for the purposes of utilization management, and is actively working with external PCPs and OB/GYN providers to promote coordination of care for members through monthly calls and onsite provider presentations. Other interventions Magellan has implemented include: providing immediate feedback to providers on the importance of coordination of care following Treatment Record Reviews (TRR) to ensure quality improvement, requesting Performance Improvement Plans (PIP) for providers who do not meet the minimum performance thresholds for coordination of care, expanding monitoring elements to collect more comprehensive data surrounding coordination of care on the TRR audit tool, and conducting trainings with high volume inpatient hospitals on the importance of coordination of care. Magellan will continue monitoring providers and referrals to and from the Bayou Health Plans with the goal of increasing coordination of care.

SECTION 15: BEHAVIORAL HEALTH IN EMERGENCY ROOMS

The table below reflects the number of outpatient members within the LBHP who received services in hospital-based emergency rooms due to a behavioral health diagnosis. Magellan defines unique emergency room (ER) members as the number of unduplicated persons that receive services in the emergency room. Presentations equate to the number of times that these persons enter the emergency room for care, and the unique member may present to the ER multiple times. Likewise, a provider may submit multiple claims for each presentation for both a professional claim for services and a facility claim for overhead expenses. This explains why the number of claims exceeds the number of presentations and why the number of presentations exceeds the number of unique members in the table below:

UNIQUE MEMBERS PRESENTING IN EMERGENCY ROOM	EMERGENCY ROOM PRESENTATIONS	EMERGENCY ROOM CLAIMS
16,240	23,847	31,642

SECTION 16: REPORT ON QUALITY MANAGEMENT

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

- Quality Improvement/Utilization Management (QI/UM) Program Evaluation (3/1/2012 through 2/28/2013)
- Louisiana CMC Magellan Health Services – Magellan Behavioral Health Utilization Management Program Description for Medicaid Managed Care (2013)

a) Number of qualified quality management personnel employed by the SMO to review performance standards, measure treatment outcomes and assure timely access to care:

Within Section VIII of Magellan's QI/UM Program Evaluation report, the Magellan Quality Improvement Review Team is explained in detail. The team consists of nine QI Clinical Reviewers (seven LMHPs and two RNs), and conducts on-site and desktop (mail-in) chart reviews.
Note: This information can be found beginning on page 44 of the attached report.

The Recovery and Resiliency Care Management (RCM) Program currently consists of eight Care Managers and two Peer Support Specialists. RCM care managers work with inpatient facilities and eligible children in regions where CSoC is not yet implemented. A referral process from the Care Managers to the Peer Support Specialists has been established for members who may need additional supports to remain in the community. According to Magellan's QI/UM Program Evaluation report, "Care Managers complete crisis safety plans with members and attach the plan to each member's file through the Magellan system. In addition, RCM is providing education to Emergency Departments and providers about the existence and role of the RCM program" (*Section XIX. Recovery and Resiliency Care Management Program Effectiveness,* QI/UM Program Evaluation, page 69-70, 2013). Two of the RCMs are specifically assigned to work with the Bayou Health Plans to ensure care is continuously provided to members. The Louisiana CMC care managers and chief medical officer (CMO) attend monthly meetings with the plans to coordinate and ensure this outcome (*Section XIV. Coordination of Care Activities*, QI/UM Program Evaluation, page 55, 2013).

b) Mechanism utilized by the SMO for generating input and participation of members, families/caretakers, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes:

During the first contract year, Magellan established the Family, Member and Stakeholder Advisory Committee (FMSAC). FMSAC met five times during the contract year with several individuals from the community attending each meeting. According to Magellan's QI/UM Program Evaluation, "the Family, Member, Stakeholder Advisory Committee performed the following activities:

- Developed a membership roster consisting of representatives from family, advocate, member and private sector groups;
- Reviewed each category identified in the Quality Improvement work plan;
- Created and uploaded related documents to the FMASC Agenda & Minutes folder in the "G" drive Quality Improvement folder according to URAC Accreditation Standards; and
- Reviewed and prioritized goals for the upcoming calendar year" (*Section XXI. Consumer, Family and Stakeholder Input and Involvement*, QI/UM Program Evaluation, page 75).

Building from the actions of the FMSAC during the first contract year, the following additional activities are proposed in the second contract year to enhance stakeholder education and involvement regarding Magellan and the LBHP:

- Hold monthly FMSAC meetings;
- Reach out to and incorporate underrepresented community groups;
- Integrate speakers in each monthly meeting to further educate FMSAC and attendees on Magellan of Louisiana processes;
- Develop action plans for stakeholder groups with specific targets; and
- Obtain input from families, members and stakeholders on member initiatives, satisfaction survey findings, and opportunities for improvement of services to the Medicaid population (QI/UM Program Evaluation, page 76, 2013).

Additionally, the QI/UM report noted that at-risk RCM Program members were provided one-on-one and group support by Peer Support Specialists. These Peer Support Specialists continue to work with members to develop personalized plans aimed at shifting focus from institutional care to community-based services, which involved the following undertakings in 2012:

- "Identified Recovery Care Management members who could benefit from one-on-one services;
- Connected with at least 90 RCM members;
- Participated in community-based events;
- Aided in increasing awareness of services available to members; and
- Conducted CHI [Consumer Health Inventory] surveys with members telephonically and in-person" (*XXI. Consumer, Family and Stakeholder Input and Involvement*, QI/UM Program Evaluation, page 76, 2013).

Also during 2012, Magellan distributed 350,000 informational bulletins known as "fat bookmarks," which are used as an educational tool informing members of Magellan's presence in Louisiana and lists appropriate contact information for accessing services through the LBHP.

c) Documented demonstration of meeting all the federal requirements of 42 CFR 438.240 and with the utilization management required by the Medicaid program as described in 42 CFR 456:

42 CFR 456:

For the purpose of meeting the mandates of federal regulation 42 CFR 456, Magellan's clinical services department includes personnel responsible for the SMO's Care Management (CM) and Utilization Management (UM) functions. The department is organized in the following manner:

- The chief medical officer oversees the CM/UM and clinical services unit.
- The chief medical officer is supported by a medical administrator and a CM/UM administrator.
- The unit is organized by CM/UM function and includes the following components:
    - Clinical services: Inpatient (includes a manager, nine senior care managers and three care managers);
    - Clinical services: Residential and CSoC (includes a manager, four senior care managers, three care managers and five care workers);
    - Clinical services: Recovery CM (includes a manager, seven senior care managers, three care managers and one care worker);
    - Clinical services: Triage (includes a manager, eleven senior care managers and one care worker);
    - Follow up after hospital team: (includes a supervisor, one lead follow-up specialist and eleven follow-up specialists); and
    - A clinical operations project analyst.

These personnel within the clinical services department of Magellan operate the LBHP UM program as per the requirements of 42 CFR 456. Magellan's UM program is composed of three major elements:

- Certification of benefits/covered services;
- Providing adjunct benefit management services, which range from coordination of care to intensive care management for clinically complex high-risk individuals; and
- Interfacing with the Quality Improvement program through retrospective auditing of UM data to identify trends and outliers (Utilization Management Program Description for Medicaid Managed Care, page 1, 2013).

42 CFR 438.240:

As per the requirements of 42 CFR 438.240, Magellan has developed a comprehensive quality improvement program description and work plan. These documents appropriately describe the structure, processes, and measures used for accountability and performance improvement within the LBHP service delivery system. Magellan has developed a committee structure that includes a Quality Assessment/Performance Improvement (QA/PI) committee that has the responsibility for overseeing the actions/findings of the following committees:

- a Utilization Management committee;
- a Member Services committee;
- a Regional Network Credentialing committee;
- a Network Strategy committee;
- a Family, Member, Advocate and Stakeholder committee; and
- a Race and Equity committee.

Additionally, Magellan has implemented three performance improvement projects (PIPs) over the course of the contract. PIPs are CMS requirements and are part of the External Quality Review (EQR) function of managed care. They are focused initiatives used to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time. PIPs are specifically aimed at creating a favorable effect on health outcomes and member satisfaction. According to the SMO contract, Magellan is required to conduct at least two PIPs in the first contract year and a third in the second contract year that are designed to achieve sustainable and substantial improvement in clinical and non-clinical care areas. Magellan must report the status and results of each project to OBH. Magellan works toward completing each PIP in a reasonable time period agreed upon with OBH, so as to allow information on the success of its PIPs to produce new information on quality of care. Below is a listing and details surrounding the three currently approved PIPs by contract year.

Contract Year 1 PIPs:

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

One of the goals of the Coordinated System of Care (CSoC) is to ensure that children who are either in an out-of-home placement or at risk of out-of-home placement receive sufficient community-based services to improve their functioning and reduce the risk of future out-of-home placements. Ensuring appropriate referral to community-based services at the time the plan of care is developed helps decrease the risk of future out-of-home placements, ensure compliance, and improve outcomes. To monitor this measure, the Magellan CSoC and Quality Management Departments worked collaboratively to identify the number of CSoC children (age 0-21) with an established plan of care who had additional CSoC services authorized at first review (i.e. short-term respite care, independent living/skills building, crisis stabilization, parent support and training, and youth support and training). Magellan assessed the number of CSoC children with a Wraparound Agency (WAA) authorization and enrolled for at least 30 days who have an established plan of care with authorization for additional CSoC services. The first year of this PIP provides baseline data to determine the compliance rate and identify potential opportunities for improvement throughout the second year of the contract. Magellan is currently in the process of analyzing claims data to provide reports on the first and second

quarters of 2013. The preliminary data is expected to be disseminated to Magellan's Quality Improvement Committee in December of 2013.

Improve Member Access to Emergent, Urgent, and Routine Appointments:
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 health services based on the presenting issue. Timely access to care impacts patient satisfaction and clinical outcomes. It is important for the SMO to monitor the speed with which members are able to access emergent, urgent and routine services. The appointment access standards established for Medicaid members in the State of Louisiana are:

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

As part of the implementation of managed care, the LBHP identified access to care as a priority for formal performance monitoring and improvement as part of the first-year contractual requirements. Improved access to care is monitored through assessing appointment access based on several different metrics including: 1) time from request for service to determination (i.e., authorization of service); 2) time from request for service to member accessing service; 3) member satisfaction with access to care; and 4) member grievances regarding access to care. Magellan continues to monitor appointment access in order to improve the quality of care provided to members of the LBHP in the second year of the contract. *Please refer to* ***Section 11 above*** *for additional details regarding the data collected relative to this PIP.*

Contract Year 2 PIP:

Improve Follow-Up after Hospitalization (Ambulatory Follow-Up or AFU) for Members Discharged from an Acute Inpatient Setting:
Ambulatory follow-up after inpatient treatment is an important component of care management as it ensures that any recovery or stabilization that occurred during admission is not lost and that further gains may continue in the least restrictive environment possible. In addition to clinical risks, members discharged from inpatient treatment who fail to have adequate aftercare may be at risk of requiring readmission to inpatient settings, resulting in inappropriate utilization of high-cost 24-hour facility services and underutilization of appropriate outpatient services. Ambulatory follow up is monitored quarterly for improvement, but reported annually. For 2012, the Louisiana CMC Seven-Day Follow-up After Hospitalization (FAH) rate was 28 percent and the 30-Day Follow-Up After Hospitalization (FAH) rate was 48 percent. The Louisiana Quality Improvement Committee and senior management in collaboration with OBH identified this area as an opportunity for improvement and determined the need for initiation of a Performance Improvement Project. Though the focus of this project is to improve follow up after hospitalization for members discharged with mental illness, members discharged with substance use issues will be monitored to obtain a baseline going forward. In order to improve AFU, Magellan has implemented several intervening strategies, including:

- Alignment of Ambulatory Follow-up Specialists with Care Management staff to enhance consistency in coordination;
- Identification of members currently in hospital and who are receiving ACT services to identify those in need of support for follow-up services;
- Establishing Follow-up Team performance goals and incentives for achievement including incentivizing providers by linking per diems to readmission rates;
- Collaboration with Provider Relations Liaison staff to address barriers with providers;
- Daily report of members currently inpatient to ensure cases are being worked;
- Enrolling all members with high utilization of services in RCM; and
- Sending letters and conducting phone calls with the leaders of the six highest volume providers to gain buy-in and support for decreasing readmissions.

In December of 2013, it was reported at the Quality Improvement Committee meeting that these activities have resulted in an increase in the first quarter for 2013 with a 3% improvement seen for both 7-day and 30-day follow-up results. This improvement was maintained for the second quarter as well. The CMC is continuing to evaluate interventions and anticipates 3rd quarter results will show further improvement.

d) Documentation that the SMO has implemented and maintained a formal outcomes assessment process that is standardized, relatable and valid in accordance with industry standards:

OBH established the Interdepartmental Monitoring Team (IMT) to facilitate monitoring of the LBHP waivers and state plan amendment performance measures outlined for the Centers for Medicare and Medicaid Services (CMS). The IMT is composed of representatives from other state agencies, Medicaid, and different sections of OBH. The IMT meets regularly and has established a schedule for reporting and accountability with Magellan, including monthly, quarterly, semi-annual and annual reporting reviews. The IMT has two subcommittees, one for adults and one for youth, that review the data pertaining to these populations and report to the IMT. The IMT and its subcommittees receive reports, review and offer analysis, and provide feedback to Magellan. This structure was developed in late 2012 and continued forward in 2013, and it continues to refine its processes. Reports reviewed by IMT include the following general areas:

- Access
- Administrative standards
- Assessment
- Eligibility
- Enrollee rights
- Grievance
- Network
- Outcomes
- Performance guarantees
- Quality standards
- Reporting
- Survey data
- Treatment planning
- Utilization management

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

a) *Please see attached data book, tab "17a Claims Payment to Provider" for details on payments to providers in answer to part a) of question number 17 from Act 212 relative to the LBHP.*

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

SECTION 18: EXPLANATION OF PROGRAM CHANGES

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

There have been no changes in standards or processes for submission of claims by behavioral health service providers. Providers continue to use paper claims, Claims Courier and Clinical Advisor for submission of claims.

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

Changes to services within the LBHP have been primarily achieved through "In Lieu Of" agreements with Medicaid. "In Lieu Of" services are authorized under 42 CFR 438.6 and are allowed only for capitated health plans. This allows Magellan's capitated managed care plan (for adults only) to provide health-related services under the capitated rate in place of State Plan services, if it is more cost-efficient or effective. There have been six in lieu of agreements, with one agreement amended twice, since the inception of the LBHP. Details of each agreement are listed below:

1. *"In Lieu Of" request by Magellan to contract with Crisis Stabilization Units*
   This agreement allows Magellan to contract with Crisis Stabilization Units to serve as both a diversion and a step down to Emergency Room (ER) and inpatient hospitalization. The purpose of this request is to assist adult Medicaid members who have urgent or emergent needs or who need further stabilization. This service is a key component to the crisis continuum by utilizing these units in lieu of unnecessary ER or hospital utilization.

2. *"In Lieu Of" request by Magellan for outpatient psychotherapy services by a Licensed Mental Health Professional (LMHP)*
   This amendment allows Magellan to utilize LMHP services in lieu of licensed psychiatric services for outpatient psychotherapy services under CPT codes 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90857 and 90853. These codes are for individual, family and group outpatient psychotherapy and mental health assessment, evaluation and testing by the following LMHPs: Medical Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Licensed Addiction Counselor, and Advanced Practice Registered Nurse. With LMHPs now allowed to provide these services,

this in lieu of agreement allows for more cost effective reimbursement for the provision of services.

- *Request to add CPT code 90805 to "In Lieu Of" request by Magellan for outpatient psychotherapy services*
  This amendment to the above request adds CPT code 90805 for the evaluation and management services that accompany CPT code 90804.

- *Amendment to "In Lieu Of" request by Magellan for outpatient psychotherapy services by an LMHP dated March 15, 2013*
  This amendment allows Magellan to bill for CPT code 90801, which allows for reimbursement of psychiatric diagnostic interview examinations.

3. *"In Lieu Of" request by Magellan for freestanding psychiatric hospitals*
   This agreement allows Magellan to utilize freestanding psychiatric hospitals in lieu of general hospital psychiatric units. Use of freestanding psychiatric units reduces emergency department consumption, increases psychiatric bed capacity and provides a less costly alternative to general hospital beds.

4. *"In Lieu Of" request by Magellan to provide certain 1915(i) services to Serious Emotional Disturbance (SED) waiver enrollees who are age 21*
   This agreement allows Magellan to provide certain 1915(i) services, specifically, Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, and Crisis Intervention to individuals aged 21 years old who are enrolled in the SED 1915(c) waiver. Due to their age, they are no longer eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, including the rehabilitation services listed above, even though they are part of the SED 1915(c) waiver. This will maintain the level of services for those persons who are in need of these services and reduce cost of care over time.

5. *"In Lieu Of" request by Magellan to contract with Licensed Nurses*
   This agreement allows Magellan to contract with Licensed Nurses to provide services embedded in the cost of evaluation and management visits (within CPT codes 99201-99215). This "In Lieu Of" agreement was specifically aimed at making injection services to adults allowable under Medicaid in lieu of having them performed by the physician. This service delivery method aids members with receipt of medications in the most efficient and least costly manner, while also increasing compliance, reducing subsequent office visits and reducing hospitalization.

6. *"In Lieu Of" request by Magellan to contract with Residential Substance Abuse Treatment facilities treatment of adults*
   This agreement allows Magellan to contract with Institutions of Mental Disease (IMDs) to provide residential substance use treatment services for adult Medicaid members. In lieu of more costly acute detox settings and emergency rooms, this request allows Magellan to place members within contracted residential substance use treatment facilities, which are often considered IMDs due to the number of beds and populations served, in order to receive care.

c) Changes in reimbursement rates for covered services

Beginning in SFY 13, the Louisiana Behavioral Health Partnership, as part of the Medicaid program, was reduced in the budgetary process to account for a state budget shortfall. This resulted in reductions to

the adult and children's reimbursement rates. These rate reductions went into effect on 7/1/2012 at the beginning of SFY 13 as follows:

- 1.927% reduction to the adult capitated rates - effective 7/1/2012 through 2/28/2013
- FY13 reductions to the Children's Medicaid Rate Schedule of 1.44% - effective 7/1/2012
  Please see attached data book, tab "#18c Children's rate changes" for details of individual rate cuts for various children's services within the LBHP.
- Additionally, in the second contract year, beginning on 3/1/2013, the rates were readjusted in order to fall within the actuarially sound rate range as required by the contract. This adjustment was budget neutral and had no impact on overall funding.

Medicaid Eligibility Group	Original Rate 3/1/12-6/30/12	Reduced Rate 7/1/12-2/28/13	Actuarially Adjusted Rate 3/1/13-2/28/14
Non-Disabled Adult, Ages 21-64	$18.49	$18.13	$18.66
Aged, 65+	$9.10	$8.92	$8.92
Disabled Adults, Ages 21-64	$65.90	$64.63	$64.23
Medicaid Spend-down Population (Administrative PMPM Fee)	$1.92	$1.92	$1.95
Non-disabled Chile, Ages 0-20 (Administrative PMPM Fee)	$1.92	$1.92	$1.95
Foster Care & Disabled Child, Ages 0-20 (Administrative PMPM Fee)	$1.92	$1.92	$1.95
CSoC Recipients (Administrative PMPM Fee)	$135.16	$135.16	$137.56

SECTION 19: ADDITIONAL METRIC/MEASURES

The tables below reflect Medicaid allowable behavioral health services pre-implementation of the LBHP (Table 1) and post-implementation (Table 2). As indicated in these tables, the state has been able to expand the service array with many new service types. With the Federal match associated with these services, the state is able to better capitalize on its available State General Fund dollars. These services are shifting the behavioral health care landscape with a focus on building a continuum of care. Some of the new services available include:

- Assertive Community Treatment for all eligible adults 18 or older
- Addiction Disorder services, including all levels of residential care, counseling and intensive outpatient for adults and children
- New outpatient therapy provider types such as family counselors and other licensed mental health professionals for adults and children
- Access to free-standing psychiatric hospitals for adults 21 and over
- Evidence-Based Programs for youth such as Functional Family Therapy and Homebuilders
- Crisis Intervention services for children, youth and eligible adults 21 and over
- Crisis Residential services for adults 21 and over

- Psychiatric Residential Treatment Facilities for anyone under 21

- Therapeutic Group Homes for anyone under 21
- Behavioral Health services provided by schools and school systems
- Wraparound (intensive case management) services for youth in CSoC because of the high risk of out-of-home placement
- Family Support, Youth Support, Crisis Stabilization, Short-term Respite, and Independent Living Skills for youth in the CSoC

Table 1:	Medicaid Allowable Services Pre-Implementation				
Crisis	Substance Use	Adult Services	Inpatient	Outpatient	Children's Services
Emergency Room	Medical Detox	OBH/LGE Community Mental Health Clinic (CMHC) services	General Hospital	Medical and nonmedical psychologists	Psychosocial Rehabilitation/ Community Support/Family child interaction
		Medication Management/ Nursing medication administration	LSU Teaching Hospital	Advanced Practice Registered Nurse	Medication Management/ Nursing medication administration
		Psychological testing	Psychiatric Hospitals	Some nursing & social worker services	OBH/LGE CMHC services
			State Hospitals	Psychiatrist	Multi-Systemic Therapy
					Psychological testing

Table 2:	Newly Allowable Medicaid Services Post-Implementation				
Crisis	**Substance Use**	**Adult Services**	**Outpatient**	**Children's Services**	**CSoC Children**
Telephonic crisis triage	Medically Monitored/Supported Residential Detox	Assertive Community Treatment (ACT)/ Forensic Assertive Community Treatment	Licensed Marriage & Family Therapist	Psychiatric Residential Treatment Facility	Psychiatric Residential Treatment Facility
Mobile Services (face to face)	Clinically Managed Residential Detox (Social Detox)	Psychosocial Rehabilitation	Mental Health Rehabilitation	Community Psychiatric Support Treatment	Community Psychiatric Support Treatment
Crisis residential	Ambulatory Detox (Outpatient)	Community Psychiatric Support Treatment	Licensed Professional Counselor	Nonmedical Group Homes	Nonmedical Group Homes
Crisis intervention	Outpatient Treatment	Crisis intervention	Individual Therapy	Crisis intervention	Crisis intervention
	Intensive Outpatient Programs (IOP)	Telepsychiatry	Licensed Clinical Social Worker	Therapeutic Group Homes	Therapeutic Group Homes
	Substance use residential treatment center	Federally Qualified Health Center (FQHC)	Licensed Addiction Counselor	Psychotherapy	Psychological testing
	Suboxone	Psychotherapy	CMHC/FQHC	Case conference	Case conference
		Intensive Case Management		Therapeutic Foster Care	Therapeutic Foster Care
		Electroconvulsive Therapy		Functional Family Therapy	Functional Family Therapy
					Crisis stabilization
					Short-term respite
					Psychosocial Rehabilitation
					Multi-Systemic Therapy
					Wraparound Facilitation
					Independent Living/ Skills Building
					Parent/Youth Support & Training

In addition to the expanded service array allowable under Medicaid through the LBHP, new providers are also able to bill for allowable services under the LBHP. Expansion to new providers primarily consisted of Licensed Mental Health Professionals (LMHPs) and new facilities/agencies. In addition to the comparative list below, some outpatient facilities are also newly allowed to bill for behavioral health services under the LBHP expansion:

Pre-LBHP Implementation	Post-LBHP Implementation
Psychiatrists	Psychiatrists
Psychologists (limited)	Psychologists (expanded)
Social Workers (limited)	Social Workers (expanded)
Licensed Clinical Social Workers (limited)	Licensed Clinical Social Workers
Community Mental Health Centers/Clinics	Community Mental Health Centers/Clinics
Mental Health Rehabilitation Programs	Mental Health Rehabilitation Programs
Multi-Systemic Therapy (MST)	Multi-Systemic Therapy (MST)
	Licensed Addiction Counselors
	Licensed Professional Counselors
	License Marriage & Family Therapists
	Residential Treatment Centers
	Substance Use Treatment Facilities
	School Based Health Clinics
	Certified Addictions Counselors, Advanced Practice Registered Nurse, & Other Masters Therapists (limited)

Magellan continues making progress in improving provider capacity as follows:

Provider/Facility Type	**Number/Increase**
In-patient psych capacity for adults	Up 87%
Other Master's Provider Types	200 new providers
Crisis Intervention providers	250 new providers
Psychiatric Residential Treatment Facility beds	128 new beds; 60 more set to open
Therapeutic Group Home beds	14 new beds
Therapeutic Foster Care Beds	250 beds contracted
Non-Medical Group Home Beds	230 beds contracted
Independent Living Skills Providers	29 new providers
Short-term Respite Providers	14 new providers
Crisis Stabilization Providers	4 new providers
All CSoC Service Providers	Up 26% quarter over quarter

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

- Providing a single point of entry available 24/7/365 with two in-state call centers.
- Coordinating care for members, including referral, assistance with eligibility, treatment planning, utilization review, follow-up care, assistance with discharge planning and placement, and peer support.
- Providing a free electronic behavioral health record to all eligible providers that also serves as the state's system for the uninsured.
- Providing intensive case management for people with special health care needs, such as pregnant women with addiction disorders or women with dependent children with co-occurring disorders.

- Managing dollars spent in the system to focus on community-based care.
- Providing quality review of providers and technical assistance to improve care.
- Investigating complaints of fraud and/or abuse.
- Processing and paying claims for services for both adult and children populations with Medicaid, as well as those additional services funded through the Department of Children and Family Services (DCFS) and the Office of Juvenile Justice (OJJ).
- Fostering transformation of the system with programs that include:
  - Cultural competency standards and training;
  - Recovery, resiliency and peer support;
  - MyLIFE (Magellan Youth Leaders Inspiring Youth Empowerment)for youth (a peer-based support group);
  - Support for families; and
  - Liaisons specialized to DCFS, OJJ and DOE.

CONCLUSION

In conclusion, as the LBHP transitions into its next phase of operation and focuses on monitoring and quality measurements, OBH will work diligently to ensure that the legislature, Louisiana residents, including behavioral health populations served and other LBHP stakeholders are aware of the activities that are taking place and resulting outcomes. OBH will continue to comply with state and federal reporting requirements, such as those outlined in Act 212 of the 2013 Regular Session of the Legislature. Specifically, OBH will provide an annual LBHP managed care transparency report to the legislature, and post all LBHP bulletins and guidance on the OBH-LBHP website.

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