

C-7A.2.15 (h) Iowa Plan 2008 Quality  
Assessment and Performance  
Improvement Plan



**MAGELLAN HEALTH SERVICES /**  
**MAGELLAN BEHAVIORAL CARE OF IOWA**  
**IOWA CARE MANAGEMENT CENTER**

**QUALITY IMPROVEMENT PROGRAM DESCRIPTION**

**for the**

**IOWA PLAN FOR BEHAVIORAL HEALTH**

**JULY 2008 – JUNE 2009**

**Magellan Behavioral Care of Iowa / Magellan Health Services –  
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The Quality Improvement Program Description (QI Program Description) for the Iowa Plan for Behavioral Health describes the Quality Improvement program, philosophy, structure and goals for the July 2008 – June 2009 contract year as administered by Magellan Behavioral Care of Iowa, the Magellan Health Services Iowa Care Management Center. Attached to the QI Program Description is the annual Quality Improvement (QI) Work Plan, which specifies goals and prioritized objectives for 2008-2009. Information related to the Utilization Management (UM) Program is contained in the 2008-2009 Utilization Management Program Description in Appendix E.

## **I Introduction**

Magellan's Iowa Care Management Center (CMC) manages mental health and substance abuse services in a variety of settings delivered by providers from multiple disciplines. The population served by the Iowa CMC includes individuals eligible to receive services through the Iowa Plan for Behavioral Health (Iowa Plan), Iowa's behavioral health managed care program for Medicaid enrollees and DPH-funded participants. The Iowa Department of Human Services (DHS) is the State authority for Iowa Plan Medicaid mental health and substance abuse services. The Iowa Department of Public Health (DPH) is the State authority for Iowa Plan substance abuse services funded by federal block grant and state appropriations, collectively referred to as DPH-funding. The Iowa CMC also manages specific services for other customers, as assigned by Magellan Health Services.

The Iowa CMC is the direct responsibility of the General Manager. The Iowa QI program is managed by the QI Director who is supported by CMC and Magellan corporate staff. The Utilization Management program, which focuses on the management of CMC recovery/resiliency initiatives, is managed by the Chief Clinical Officer. Coordination of care and medical integration activities are managed by the Medical Director. Oversight of the QI program is provided by the Iowa Plan Quality Improvement Committee (QIC) (See Section V. Quality Improvement Committee Structure and Appendix A). Corporate oversight of the Iowa QI Program occurs through a corporate committee structure (see Appendix B).

The Institute of Medicine's (IOM) *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* set's forth the following aims for improving consumer and family member care: safe, effective, patient-centered, timely, efficient and equitable. These aims guide the Iowa QI program. QI Program activities are based on the best scientific knowledge available and designed to meet the individual needs of consumers and family members while supporting recovery and resiliency.

## **Vision**

In collaboration with our clinical utilization management program, the Iowa QI program seeks to create an environment that fosters the hope and belief that individuals and families experiencing mental illness and addiction can lead fulfilling and rewarding lives that include:

- A sense of belonging in the community
- A safe and stable place to live
- Skills to achieve wellness
- Days filled with purpose, including meaningful employment
- A strong voice in their own treatment and recovery
- Hope and confidence in themselves and their future

## **Mission**

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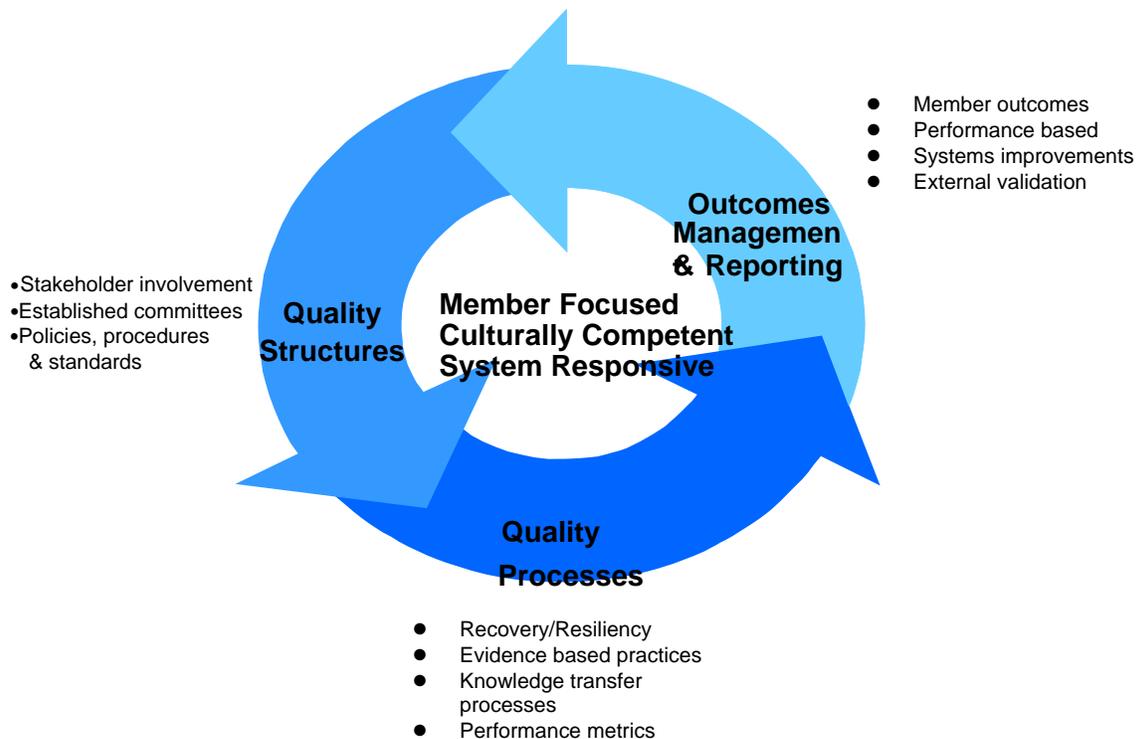
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The mission of the Iowa QI program is to transform the behavioral health services delivery system in Iowa so treatment and support services promote the principles of recovery and resiliency for service recipients and family members. To achieve this mission, the program is committed to:

- Transforming existing systems, services, programs, and supports by promoting the principles of recovery and resiliency;
- Creating, developing and implementing new and innovative programs and supports that integrate the principles of recovery and resiliency;
- The development and monitoring of measurable outcomes that demonstrate progress toward achievement of our vision.

**II Quality Improvement Process**

The Iowa QI Program will accomplish its mission and promote its vision through the implementation of a results-oriented focus on Total Quality Management and Continuous Quality Improvement. The QI Program Description is a dynamic document that is responsive to the voices of all stakeholders, flexible in its actions, and readily modifiable as conditions warrant. With input from a broad spectrum of stakeholders, accepted QI practices such as Define, Measure, Analyze, Improve, Control (DMAIC), Plan, Do, Study, Act (P/D/S/A) and Best Clinical and Administrative Practice Framework (BCAP) will be employed to insure the timely identification of barriers and interventions to insure improvement. Intervention effectiveness will be monitored through frequent measurement and re-measurement. The following illustrates how QI method is integrated into all quality improvement activities and programs, thus promoting a *culture of quality*.



**III Purpose, Goals and Objectives**

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This QI Program Description describes the specific objectives and activities that will be used to achieve Iowa CMC purposes and goals.

The primary **purpose** of the Iowa CMC is the management of high-quality, innovative recovery and resiliency services that:

- Demonstrate accountability through the use of utilization, satisfaction and function based outcomes measures keyed to appropriate goals and targets.
- Develop and utilize innovative interventions and programs that promote consumer and family member choice, direction and control while reducing stigma.
- Endeavor to transform healthcare system delivery around the principles of recovery, resiliency and cultural competence.

The Iowa QI Program advances recovery and resiliency services through achievement of the following **goals**:

**Broad Goals:**

1. Fulfill the requirements of the **Iowa Plan contract**.
2. Maintain a comprehensive and coordinated **Iowa Plan Quality Improvement (QI) program**.
3. Meet/exceed the standards of the **Iowa Plan Performance Indicators**.
4. Meet standards for **Magellan QI departments**.

**Specific Objectives:**

1. **Advisory Committees**  
Work with the three Iowa Plan advisory committees and with other stakeholder groups.
  - a. **Clinical Advisory Committee** advises Magellan on Iowa Plan clinical issues.
  - b. **Consumer/Family Advisory Committee** advises Magellan on Iowa Plan issues from the consumer and family perspectives.
  - c. **Iowa Plan Advisory Committee** advises DHS and DPH on Iowa Plan strategic and operational issues and provides for ongoing public input.
  - d. Hold **Provider Roundtables** over the ICN with continuing education presentations as well as Iowa Plan updates.
  - e. Host **Children's Mental Health Stakeholders Roundtables, IPR Roundtables, Women and Children's Coordinators Meetings, Co-Occurring Roundtables, and Peer Support Roundtables**.
  - f. Attend other stakeholder meetings as invited.
2. **Best Practices**
  - a. **Support recovery and resiliency** in all activities by all staff, with leadership from the **Consumer/Family Advocate**.
  - b. **Support cultural competency** in all activities by all staff with the guidance of the Cultural Competency Workplan.
  - c. Continue to develop, support, and monitor Medicaid **Community Reinvestment projects**.
  - d. Promote dissemination of and compliance with Magellan **Clinical Practice Guidelines**.

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- e. Continue current PIPs, including **Peer Support** and **Behavioral Health and Medical Care Coordination**.
  - f. Initiate **Performance Measures**, as identified by the QI Committee, to understand trends and improvement opportunities.
  - g. Continue participation in DPH **Network for Improving Addiction Treatment (NIATx)** activities, including the **STAR-SI** project.
  - h. Participate in ongoing DPH and DHS initiatives relevant to **integration of services for co-occurring disorders**.
3. **Children's System of Care**
- a. Assure service coordination/integration for Medicaid-enrolled children in DHS's **Child Welfare** system, e.g. through Joint Treatment Planning.
  - b. Continue to support the Remedial Services system through provision of behavioral health assessments by Licensed Practitioners of the Healing Arts.
4. **External Reviews**
- a. Participate in DHS's annual **External Quality Review** of the Iowa Plan.
    - Conduct annual review of member materials, including the **Client Handbook** and **Provider Directory**.
    - Mail required **annual notification** newsletter to Medicaid enrollees.
  - b. Maintain **Utilization Review Accreditation Commission** accreditation.
  - c. Meet Iowa Insurance Division **Limited Service Organization** requirements.
  - d. Participate in other external reviews as scheduled, such as:
    - **Centers for Medicare and Medicaid Services**
    - **Substance Abuse and Mental Health Services Administration**
5. Initiate one new **Prevention Project**. Continue the current **Postpartum Depression, Sibling ADHD/Parental Depression, Reward for Quality, and Behavioral Health and Medical Care Coordination** prevention projects.
6. **Provider Monitoring and Technical Assistance**
- a. Analyze trends in **Critical Incidents, Funding Source Monitoring, Provider Incidents, and Provider Profiling** and provide technical assistance, as indicated.
  - b. Generate and monitor annual **DPH provider contracts**.
  - c. Continue collaboration with the **Drug Utilization Review Commission**.
  - d. Conduct **retrospective clinical on-site reviews** with all Iowa Plan substance abuse providers and selected mental health providers, including hospitals and Community Mental Health Centers.
    - Complete **annual substance abuse retrospective review summary** and submit with QI Annual Report.
  - e. Write Iowa Plan specific content for Magellan's quarterly **Provider Focus** newsletter.
  - f. Continue to maintain **Provider Services Subcommittee** to collaborate internally between Provider Network and Quality Improvement departments.

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7. **Satisfaction Surveys**
  - a. Complete two rounds of **Client Satisfaction Surveys** for DPH substance abuse clients and for Medicaid mental health and substance abuse clients, with Medicaid responses sorted for adults and children/adolescents.
  - b. Conduct one **Provider Satisfaction Survey**.
  
8. Continue **Magellan staff development and training** efforts including on-site CEUs.
  - a. Assess access to **Spanish-speaking staff** and recruit staff, as indicated.
  - b. Continually monitor **staff orientation** efforts and required **annual trainings**.
  - c. Provide training focus on **recovery and resiliency** as well as **cultural competency**.
  
9. Continue **website enhancement** and **interactive functionality**.
  
10. Participate in Magellan's **annual policy review**. Customize policies where indicated.
  
11. Continue **DHS and DPH oversight** activities including:
  - a. monthly Management and Quality Improvement Committee meetings and twice a month Departments Meetings, including review of notice letters
  - b. delivery of the QI Annual Report, including a Fraud and Abuse Summary, QI Quarterly Reports, and monthly Data Reports

In order to accomplish these goals, the Iowa CMC develops an annual QI Work Plan outlining the prioritized objectives and planned activities for the coming year. Prioritized objectives and activities are identified through a review of:

- Consumer, family member and stakeholder feedback, particularly through advisory groups
- The previous year's Annual Quality Assurance Report, which serves as the annual QI Program Evaluation
- Customer requirements and needs
- Accreditation and regulatory requirements
- Audit findings
- Monitoring of high-risk and other specific member populations

The Magellan Quality Program monitors and evaluates performance improvement across the range of covered services provided by the CMC. The program is intended to ensure operational structures and processes lead to desired outcomes for service recipients and family members. Please see Appendix (G), Iowa CMC 2008 Innovation Plan, of this document for a further description of the Iowa CMC's prioritized objectives for 2008.

#### **IV. Authority and Accountability**

The Magellan Health Services Board of Directors has designated the National Quality Council (NQC) and its subcommittees to provide corporate oversight of the Iowa QI program.

Key Iowa staff accountable for implementation of the Iowa Plan QI program include: **1. General Manager**The General Manager has overall responsibility for the success of the Iowa QI program and is further responsible for adequate resources and staffing. Specific activities include: serving as

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co-chair of the QI Committee, co-chair of the Clinical Advisory Committee, supporting the Iowa Plan Advisory Committee, attending Management Meetings with DHS and DPH, coordinating efforts to improve clinical and service quality while promoting recovery and resiliency, and monitoring quality activity reports so that the QI program scope is maintained and goals are achieved.

## **2. Quality and Compliance Director**

The Quality and Compliance Director reports directly to the General Manager and has the day-to-day authority and responsibility for directing the management and advancement of the QI and compliance programs. The Quality and Compliance Director serves as co-chair of the QI Committee, attends Management Meetings and Departments Meetings with DHS and DPH, attends the Clinical Advisory Committee and the Consumer/Family Advisory Committee, supports the Iowa Plan Advisory Committee, and directs Provider Roundtables. Some of his/her activities include coordination of the development of the Quality Improvement (QI) Program Description, Quality Work Plan, QI Quarterly Reports (QI Work Plan updates), and the Annual Quality Assurance Report (QI Program Evaluation). The Quality and Compliance Director is responsible for the coordination of quality improvement activities, QIC minutes, agenda, data reporting, analysis, coordination with CMC recovery and resiliency programs, implementation and review of the Magellan safety program and adherence to corporate compliance policies and procedures.

## **3. Medical Director**

The Medical Director reports to the General Manager and is responsible for the development of a medical integration plan, directing recovery, resiliency and prevention activities, and provides oversight of assigned physician advisors. The Medical Director has significant involvement in the CMC clinical operations, including interface with the QI Department, primarily through day to day support of and consultation with clinical staff. The Medical Director serves as chair of the Professional Provider Review Committee, is co-chair of the Clinical Advisory Committee and the Utilization Management Subcommittee, and attends the QI Committee.

## **4. Chief Clinical Officer**

The Chief Clinical Officer reports to the General Manager and has responsibility for the direction and management of clinical operations, including development and coordination of the Utilization Management Program, which includes all recovery and resiliency activities. The Chief Clinical Officer serves as co-chair of the Utilization Management Subcommittee and attends the Clinical Advisory Committee, Departments Meetings with DHS and DPH, and the QI Committee.

## **5. Director of Operations**

The Director of Operations reports to the General manager and oversees daily operational activities including data systems and processes that support the QI Work Plan and the QI Committee and its subcommittees. The Director of Operations attends the QI Committee and presents updated data in the QI Work Plan, noting trends and providing analysis. The Director of Operations also attends Departments Meetings with DHS and DOH and Member Services Subcommittee meetings.

## **6. Quality Improvement Clinical Reviewers**

QI Clinical Reviewers report to the Quality and Compliance Director and have day-to-day responsibility for specific QI program activities, including on-site review of provider records, managing assigned projects, and coordinating assigned QI activities. QI Clinical Reviewers attend

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the QI Committee and chair or participate in the CEU/Professional Development Subcommittee, Utilization Management Subcommittee, Provider Roundtables, and other stakeholder groups.

### **7. Quality Improvement Specialists**

The two QI Specialists report to the Director of Operations and the Quality and Compliance Director respectively. The QI Specialists are collectively responsible for data management and reporting that support the QI Committee, as well as drafting QI Committee agendas and minutes and quarterly and annual reports; incident tracking and reporting; and other QI activities as assigned.

### **8. Clinical Learning Lead**

The Clinical Learning Lead reports to the Quality and Compliance Director and is responsible for staff orientation, development, and training and for provider education through Provider Roundtables and the Provider Focus newsletter. The Clinical Learning Lead attends the QI Committee, chairs the CEU/Professional Development Subcommittee, and is responsible for carrying out the CMC Cultural Competence Plan.

### **9. Consumer/Family Advocate**

The Consumer/Family Advocate reports to the Quality and Compliance Director and is responsible for working with members, families, and advocacy group representatives to assure input into Iowa CMC operations and attention to consumer/family priorities. The Consumer/Family Advocate attends the QI Committee and chairs the Member Services Subcommittee, facilitates the Consumer/Family Advisory Committee and the Children's Mental Health Stakeholders Roundtable, and is responsible for carrying out the CMC Innovations Plan.

### **10. Appeals Coordinator**

The Appeals Coordinator reports to the Quality and Compliance Director and is responsible for assuring Appeal and Grievance Compliance.

**V. Iowa Quality Improvement Committee Structure** This document includes a description of the Iowa CMC's administrative structure for oversight of the QI Program, including the roles and responsibilities of:

- The governing or policy-making body;
- The Quality Improvement Committee
- The Iowa CMC Management Team
- QI Program staff.

Through an expansive QI Committee structure, the Iowa CMC, with extensive stakeholder input, ensures ongoing communication and collaboration between the QI Program and other functional areas of the organization. The CMC formally evaluates and documents the effectiveness of its QI Program strategy and activities annually. The QI Program is staffed with sufficient appropriately qualified personnel to carry out the functions and responsibilities in a timely and competent manner. Staff qualifications for education, experience and training are developed for each QI position and a current organizational chart is maintained to show reporting channels and responsibilities for the QI Program.

Listed below are the committees that support the Iowa QI Program. A diagram of the Iowa QI Committee structure can be found in Appendix A. **Iowa Quality Improvement Committee**

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**(QIC) Authority and Role** The Iowa QI Committee, co-chaired by the General Manager and the Quality and Compliance Director, has authority over the Iowa QI program. In this role, it is responsible for: approval and ongoing monitoring of QI and Utilization Management program documents, establishing and maintaining mechanisms for the identification and review of quality of care and service issues, providing a method for providers, consumers, family members, and other relevant stake holders to have input into the QI program, and reviewing reports from its subcommittees.

QI Committee subcommittees include the following:

- Utilization Management Subcommittee
- Member Services Subcommittee
- Consumer/Family Advisory Committee (Member Advisory Group)
- Professional Provider Review Committee
- Clinical Advisory Committee (Provider Advisory Group)
- CEU/Professional Development Subcommittee

The QI Committee reports to the Magellan National Quality Council (NQC). The QI Committee provides the completed QI Program Description and annual Quality Work Plan, QI Quarterly Reports (Quality Work Plan Updates), and Annual Quality Assurance Report (QI Program Evaluation) to the NQC. The QI Quarterly Reports (Work Plan Updates) describe the progress in meeting the objectives and completing planned activities noted in their annual Quality Work Plan. The QI Committee meets monthly.

**Functions**

- Review and approve the QI Program Description and QI Work Plan annually, and submit these to the NQC.
- Review and analyze care and service performance measures (including core performance indicators, performance guarantees and outcomes data) as identified in the QI Work Plan.
- Develop and oversee quality improvement initiatives
- Review QI Quarterly Reports (Work Plan Updates)
- Identify, design, and monitor Performance Improvement Projects (PIPs), Performance Measures (PMs), and other quality improvement activities
- Approve and oversee Iowa CMC policy implementation
- Oversee the activities of subcommittees and provide coordination between departments in the QI structure
- Review Patient Safety and Recovery and Resiliency program activities and initiatives.
- Review Medical Integration/Coordination of Care initiatives and activities
- Review and approve the Annual Quality Assurance Report (QI Program Evaluation) and submit it to Magellan's QI Department for review and approval by the NQC.
- Obtain provider, consumer and family member input through advisory groups and committees

**Membership**

- General Manager (co-chair)
- Quality and Compliance Director (co-chair)
- Chief Clinical Officer

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- Clinical Learning Lead
- Consumer/Family Advocate
- Consumer representative
- DHS Bureau Chief for Managed Care and Clinical Services
- DHS Iowa Plan Program Manager
- DPH Licensure Bureau Chief
- Director of Operations
- Family representative
- Medical Director
- National QI Director
- Provider representatives
- QI Clinical Reviewers
- QI Specialists

**Utilization Management Subcommittee**

Authority and Role

The UM Subcommittee has authority over Iowa Utilization Management and Intensive Care Management programs. The UM Subcommittee is responsible for adopting and implementing Magellan and Iowa Plan clinical policies and standards and developing operational procedures consistent with the policies. The UM Subcommittee is responsible for prevention activities.

The UM Subcommittee is co-chaired by the Medical Director, Chief Clinical Officer and a QI Clinical Reviewer. It reports to the QI Committee and provides signed and dated minutes and quarterly updates to the QI Committee. The UM Subcommittee meets monthly.

Functions

- develop and approve the annual UM Program Description and submit to the QI Committee and the National Clinical Management Committee
- review and evaluate patterns of care and key utilization indicators
- approve and implement Iowa mental health psychosocial necessity criteria
- assist with the development of quality improvement activities related to utilization
- evaluate and address potential over- and under-utilization of services
- evaluate consistency in use of clinical criteria
- oversee prevention activities
- oversee and monitor utilization management activities, including Intensive Care Management
- oversee patient safety activities

Membership

- Chief Clinical Officer (co-chair)
- Medical Director (co-chair)
- QI Clinical Reviewer (co-chair)
- Care Management Manager
- Care Manager
- QI Specialist

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**Member Services Subcommittee**

Authority and Role

The Member Services Subcommittee, chaired by the Consumer/Family Advocate, has authority over the implementation and on-going monitoring of member services activities of the Iowa CMC. The Member Services Subcommittee is responsible for improving client services, including telephone access, provider availability, compliments, grievances, member materials, non-clinical appeals, satisfaction surveys, and confidentiality issues.

The Member Services Subcommittee reports to the QI Committee and provides quarterly updates and signed and dated minutes to the QI Committee. The Member Services Subcommittee meets quarterly.

**Functions**

- review and analyze performance measures relating to member services
- identify and recommend quality improvement activities to the QI Committee
- conduct an annual review of the Client Handbook, the Provider Directory, and the annual member notification newsletter
- review input and recommendations from members and oversee incorporation into the QI program, UM program, Clinical Practice Guidelines, member materials, and prevention activities

**Membership**

- Consumer/Family Advocate (chair)
- Administrative Manager
- Director of Operations

**Consumer/Family Advisory Committee**

Authority and Role

The Consumer/Family Advisory Committee solicits input from clients, consumers, enrollees, family members, advocates, and other stakeholders about the Iowa Plan.

The Consumer/Family Advisory Committee reports to the Iowa QI Committee and provides quarterly updates and minutes to the QI Committee. The Consumer/ Family Advisory Committee meets quarterly and is led by the Consumer/Family Advocate.

**Functions**

- annual review and input on the QI program and QI goals
- year-end review of QI performance, including Performance Indicators
- feedback on operational issues
- input on service development/improvement opportunities
- input on member materials
- review of Client Satisfaction Survey results
- input on the Iowa Plan Grievance System
- input on provider accessibility standards

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**Membership**

- Consumer/Family Advocate (facilitator)
- consumer and family representatives, as approved by DHS and DPH
- DHS Iowa Plan Program Manager
- interested advocates, consumers, family members, and other stakeholders
- Peer Specialist
- Quality and Compliance Director

**Professional Provider Review Committee (PPRC)**

**Authority and Role**

The Professional Provider Review Committee (PPRC) oversees the suitability and quality of network providers and, for the purposes of credentialing and re-credentialing, is responsible for a component of local peer review of assigned providers.

The PPRC reports to the QI Committee and the Magellan National Professional Provider Review Committee (NPPRC). The PPRC is chaired by the Medical Director and provides signed and dated minutes and quarterly reports of activities to the QI Committee and submits reports on decisions to the NPPRC. The PPRC meets twice each month.

**Functions**

- define size, composition, and training needs of the provider network
- conduct initial credentialing review determinations of assigned providers
- conduct re-credentialing review determinations of assigned providers
- monitor treatment record review activities, take appropriate actions, and report to the QI Committee
- monitor patient safety activities and data
- monitor medical integration/coordination of care activities
- oversee implementation of Clinical Practice Guidelines
- review quality file information related to credentialing/re-credentialing:
  - treatment record reviews
  - compliments or Grievances
  - Critical Incident/Provider Incident reviews
  - Satisfaction Survey data
  - utilization data
  - QI activities

**Membership**

- Medical Director (chair)
- Area Network Manager
- Care Management Manager
- Chief Clinical Officer
- Network Coordinator
- provider representative, Psychiatry

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- provider representative, Psychology
- provider representative, Social Work
- QI Specialist

**Clinical Advisory Committee (Provider Advisory Group)**

Authority and Role

The Clinical Advisory Committee solicits input from providers and other stakeholders about Magellan’s implementation of the Iowa Plan, including the QI program and key clinical and service decision areas, such as Clinical Practice Guidelines, psychosocial necessity criteria, and continuity and coordination of care.

The Clinical Advisory Committee reports to the QI Committee and provides quarterly updates and minutes to the QI Committee. The Clinical Advisory Committee meets quarterly and is co-chaired by the General Manager and the Medical Director.

Functions

- collaboration with providers serving the Iowa Plan population
- review of the QI program and activities
- review of accessibility standards
- review and comment on clinical outcomes activities
- review and comment on patient safety activities
- input on clinical protocols and processes, including annual review of the mental health utilization management criteria
- recommendations on level of functioning scales
- input on performance improvement activities
- review of Clinical Practice Guidelines and new technology assessments

Membership

- General Manager (co-chair)
- Medical Director (co-chair)
- Chief Clinical Officer
- DHS Iowa Plan Program Manager
- provider representatives, as approved by DHS and DPH
- Quality and Compliance Director

**CEU/Professional Development Subcommittee**

Authority and Role

The Continuing Education Unit/Professional Development Subcommittee is responsible for all staff development activities including orientation, on-site continuing education, and professional development activities.

The CEU/Professional Development Subcommittee reports to the QI Committee and updates the QI Committee on its activities each quarter. The CEU/Professional Development Subcommittee is chaired by the Clinical Learning Specialist. Membership is rotated among Iowa CMC staff to facilitate input. The CEU/Professional Development Subcommittee meets quarterly, at a minimum.

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**Functions**

- manage new employee orientation processes and materials
- manage Magellan annual employee training processes and materials
- maintain Iowa CMC status as a CEU provider for psychologists, social workers, substance abuse counselors, mental health counselors, and marriage and family therapists
- maintain working relationship with the RN CEU provider
- select topics and speakers for on-site presentations and schedule presentations, prepare/distribute materials, videotape presentations, and monitor and document attendance
- coordinate Provider Roundtable activities
- coordinate the receipt of CEU certificates
- draft articles for FOCUS, the Magellan quarterly provider newsletter

**Membership**

- Clinical Learning Lead (chair)
- Care Managers (mental health)
- Care Managers (substance abuse)
- QI Clinical Reviewers

**Additional Iowa Committees and Stakeholder Groups**

The following committees and groups also inform the QI Committee:

**Children's Mental Health Stakeholders Roundtable**

**Role**

The Children's Mental Health Stakeholders Roundtable provides a forum for individuals and advocacy representatives to meet on issues related to children's mental health and well-being. The Roundtable meets quarterly and is facilitated by the Consumer/Family Advocate. Updates are provided through QI Quarterly Reports and the Annual Quality Assurance Report.

**Functions**

The Children's Mental Health Stakeholders Roundtable brings interested individuals together for shared discussion toward eliminating barriers for children and their families. The Roundtable acts as a resource for families, advocacy groups, and policy-makers .

**Participants**

- Consumer/Family Advocate (chair)
- advocacy representatives
- family members
- other stakeholders

**Departments Meeting**

**Role**

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Departments Meetings are one mechanism for discussion of Iowa Plan implementation and decision-making on operations and for oversight by DHS and DPH. Meetings are facilitated by the QI Director and are held twice a month. Written agendas and minutes are maintained. Agenda topics are reported in QI Quarterly Reports and the Annual Quality Assurance Report.

**Functions**

- support discussion and decision-making for Iowa Plan operations
- inform DHS and DPH of Iowa Plan activities and issues
- provide updates on Iowa Plan activities for the following standing agenda areas:
  - Care Management
  - Claims/MIS
  - Community Relations
  - DHS Medicaid
  - DPH substance abuse services
  - Network Development
  - Quality Improvement

**Participants**

- Quality and Compliance Director (facilitator)
- Chief Clinical Officer
- DHS County Systems Consultant
- DHS Iowa Plan Program Manager
- DPH Licensure Bureau Chief
- Director of Operations
- EFR/SAMI Iowa Plan Substance Abuse Director

**Iowa Plan Advisory Committee**

**Role**

The Iowa Plan Advisory Committee meets quarterly to advise DHS and DPH on Iowa Plan strategic and operational issues and provides for ongoing public input. Written agendas and minutes are maintained. Activities are reported to the QI Committee and in QI Quarterly Reports and the Annual Quality Assurance Report.

**Functions**

- review of Magellan's annual Iowa Plan quality assessment and performance improvement plan (QA Plan)
- input on annual Iowa Plan QI goals
- review of Magellan's year-end performance relative to the QA Plan, including review of the Performance Indicators
- feedback on operational issues experienced by consumers, family members, and/or providers
- input on potential areas for service development or service improvement

**Membership**

- DHS Bureau Chief for Managed Care and Clinical Services

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- DHS Iowa Plan Program Manager
- DPH Deputy Director/Director of the Division of Behavioral Health and Professional Licensure
- DPH Licensure Bureau Chief
- General Manager
- Quality and Compliance Director
- representatives of Iowa Plan stakeholder groups, with one member designated as meeting Facilitator

**Management Meeting**

**Role**

DHS, DPH, and Magellan meet monthly to discuss Iowa Plan policy issues. General discussion areas are reviewed in the QI Quarterly Report and the Annual Quality Assurance Report.

**Functions**

- review and decide on Iowa Plan policy issues
- provide updates on Iowa Plan activities
- support DHS and DPH oversight of the Iowa Plan and Magellan

**Participants**

- DHS Bureau Chief for Managed Care and Clinical Services
- DHS Iowa Plan Program Manager
- DPH Deputy Director/Director of the Division of Behavioral Health and Professional Licensure
- DPH Licensure Bureau Chief
- General Manager
- Quality and Compliance Director

**Provider Roundtables**

**Role**

Provider Roundtables support provider input into Iowa Plan operations and planning. Activities and input are reported to the QI Committee and are included in the QI Quarterly Report and the Annual Quality Assurance Report. Provider Roundtables are offered statewide over Iowa's Interactive Communication Network and include continuing education presentations for attendees.

**Functions**

- solicit input on Iowa Plan activities
- provide updates on Iowa Plan activities including:
  - care management processes
  - Clinical Practice Guidelines
  - clinical on-site reviews, including treatment and discharge planning and record documentation
  - Community Reinvestment projects
  - network and service development

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- Provider Profiling
- QI activities
- offer continuing education presentations

**Participants**

- Chief Clinical Officer
- Clinical Learning Lead
- Consumer/Family Advocate
- County Central Point Coordinators
- DHS representatives
- DPH representatives
- Intensive Care Managers
- Medical Director
- professional provider organization representatives
- providers
- QI Clinical Reviewers
- Quality and Compliance Director
- QI Specialists

**VI. Scope of Quality Improvement Program**

Quality monitoring is embedded throughout operational and care delivery processes. The comprehensive approach to quality, as described in section VI. Scope of Quality Improvement Program, synthesizes multiple QI processes to yield a thorough program of checks and balances. The QI Program monitors and evaluates performance improvement across the range of covered services provided by the Iowa Plan. The program is intended to ensure operational structures and processes lead to desired outcomes for consumers and family members. The scope of the QI program involves the systematic monitoring, improvement, and evaluation of activities related to:

- Care Management- utilization management- appeals- medical necessity criteria- clinical practice guidelines- service standards
  - collaboration and coordination with primary care systems- technology assessment- training and professional development
- Recovery and Resiliency
  - peer support services- self-directed care programs
  - evidence-based practices
  - outcomes assessment
- Intensive Care Management - effectiveness of services- resource utilization- outcomes assessment
- Outcomes management and satisfaction research - outcomes projects- member satisfaction- provider satisfaction Medical Integration/Coordination of Care
  - continuity and coordination of care
- Cultural Competency Plan
  - staff and practitioner training
  - population assessment

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- Consumer and Family Services- confidentiality of information- member communications- compliments and grievances and non-clinical appeals- member rights and responsibilities
- Access and Availability- telephonic access- provider availability
- Quality Improvement - program description- work plan, including activities, core indicator collection, analysis and oversight- annual program evaluation and reporting- Performance Improvement Projects and Performance Measures
- Prevention Projects
- Member Safety- safety management plans
  - grievance review and analysis- tracking and trending adverse incidents
  - continuity and coordination of care
- Network Management- provider selection, credentialing, re-credentialing- provider profiles- provider incidents- provider communications
- Accreditation and Regulatory Reporting

**VII. Key Program Activities**

The QI Committee conducts many activities designed to improve the quality and safety of behavioral health care and services while promoting self-management, choice and wellness to its consumers and family members. The need to respect and incorporate the preferences of consumers and families is recognized by the Iowa CMC as a core strategy for improving the quality and effectiveness of care. Presented below is a listing of key program activities:

**Accreditation** - The Iowa CMC maintains URAC accreditation as a utilization management entity and is licensed as a Limited Service Organization by the Iowa Insurance Division, as required by the Iowa Plan contract.

**Ad Hoc Focused Reviews** - When quality monitoring activities identify the need for performance improvement for select providers, Magellan conducts ad hoc reviews, which may include reviewing treatment records and documentation provided by the provider; onsite office visits; interviews with staff, consumers, families/stakeholders; and other data sources as appropriate.

**Audits** – Audits of focused care and service activities are conducted annually.

**Case Audits** – The Iowa CMC performs regular case audits to evaluate the quality of activities performed by the clinical and medical staff.

**Compliments, Grievances and Appeals** – The Iowa CMC maintains a process for responding to member, customer organization, or provider initiated grievances and appeals. The process also includes an evaluation of the nature of the grievances on an aggregate basis to determine trends and opportunities for improvement.

**Core Indicator Monitoring** – The Iowa CMC reports monthly on core sets of indicators approved by Magellan to allow benchmarking and comparisons among CMCs.

**Cultural Competency Program** – The Iowa CMC maintains a cultural competence program description identifying methods used so that individual consumers' preferences,

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needs and values are addressed and are free from discrimination. See sec. IX. Cultural Competency and Appendix F. Cultural Competence Plan for more details.

**Outcome Measures** – Magellan’s comprehensive approach to outcomes measurement and reporting, known as *Outcomes 360*, allows for the use of integrated outcomes findings—including outcomes findings from real-time sources—to drive the care management process. Quantifiable measures are used to demonstrate progress and highlight areas for continued improvement to all those involved in the recovery and resiliency process, including service providers, the customer, and most importantly, the behavioral health recipient. The primary components of the Iowa CMC *Outcomes 360* include the following:

**Consumer Health Inventory (CHI) and Consumer Health Inventory – Child (CHI-C)** Magellan has worked closely with QualityMetric, the industry leader in health status measurement, in developing the proprietary CHI and CHI-C for implementation in our public sector programs. The CHI tools rely on QualityMetric’s existing tools, including the SF-36® and SF-12®, but use a recovery and resiliency orientation in expanding the focus toward behavioral health outcomes and demonstrated improvement in members’ health and productivity. The CHI and CHI-C are Web-based tools, available in English and Spanish, designed to be completed by the service recipient and/or caretaker and to produce immediate feedback reports for both the service recipient and/or caretaker and the clinician, allowing for a flexible and responsive treatment environment.

**Performance Improvement Projects, Performance Measures, and Other Quality Improvement Activities** – As described in DHS’s Iowa Medicaid managed Care Quality Assurance System document, each contract year, Magellan either initiates or continues at least two Performance Improvement Projects (PIPs) that are designed to achieve, through on-going measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The Iowa CMC also initiates Performance Measures as indicated in order to take a closer look at trended data and determine whether intervention is needed.

**Prevention Programs** - Magellan will initiate at least one project each contract year focused on prevention. The CMC, through the QI Committee, will also review the effectiveness of those prevention programs.

**Program Documentation** – Annually, the Iowa CMC updates and approves the QI Program Description (with annual quality goals), and the Annual QI Work Plan (with scheduled activities and indicators, which are monitored for quality purposes). The Iowa CMC prepares QI Quarterly Reports, which detail progress toward goals and completed activities noted in the Annual QI Work Plan. At the end of the year, the Iowa CMC prepares the Annual Quality Assurance Report (QI Program Evaluation), which details the results of quality activities and identifies future opportunities for improvement. The Annual Quality Assurance Report includes careful consideration of all aspects of the QI program, with an emphasis on demonstrating how the QI program improved the quality of behavioral healthcare, prevention, and member services to its customers.

**Provider Inquiry and Review** – The Iowa CMC maintains a process for addressing specific provider incidents, which include corrective actions if necessary.

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**Quality of Care Concerns** - Quality of Care concerns are identified through multiple methods such as Care Managers, Customer Service Associates, Network Managers, or external means such as health plan customers, consumers or providers. When concerns are identified they are reviewed for action and resolution. Interventions include educational and/or corrective action plans.

**Satisfaction Surveys** – The Iowa CMC analyzes satisfaction data from several sources. Consumer satisfaction surveys and provider satisfaction surveys are conducted regularly and the results are analyzed through the quality improvement process.

**Silent Monitoring** – Silent monitoring audits are regularly performed on customer service associates and care managers to evaluate the quality of services provided to callers.

**Site Visits**– Site visits are conducted with all hospitals, Community Mental Health Centers, substance abuse providers, and agencies. High volume providers are visited to assure service appropriateness. Other site visits occur as indicated.

**Treatment Record Reviews** – The Iowa CMC conducts treatment record reviews at all site visits to evaluate the care provided to consumers and to monitor contract compliance.

**Utilization Management Program** – A detailed description of this document is provided in Appendix E.

### **VIII. Consumer Rights and Responsibilities**

The Iowa CMC ensures that consumers are treated in a manner that respects their rights and dignity. Through the distribution of the Member Handbook, consumers are informed of their rights and responsibilities. The member handbooks are distributed at enrollment and made available to consumers annually thereafter (unless a significant change requires dissemination).

Each Magellan employee and contracted provider employee is expected to adhere to consumer rights and responsibilities policies and receive orientation and ongoing training with respect to consumer rights.

### **IX. Cultural Competency**

The Iowa CMC is committed to a strong cultural diversity program. The CMC recognizes the diversity and specific cultural needs of its consumers and has developed a comprehensive program that addresses these needs in an effective and respectful manner. The method for provision of care is compatible with the consumer's cultural health beliefs and practices and preferred language.

#### Goals of the Cultural Competency Program

- Enable staff and systems - including affiliated providers – to deliver culturally competent services through a combination of specific recruitment and training strategies
- Implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the area
- Offer and provide language assistance services, including bilingual staff and interpreter services at no cost to those with limited English proficiency during all hours of operation

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- Make available easily understood patient-related materials, including conflict and grievance resolution materials, in the languages of the commonly encountered groups in the area
- Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing activities and initiatives
- Review and monitor all activities as well as implement a continuous quality improvement review that includes: Network access and availability measures, Telephone access information, related core performance indicators and correspondence, etc.

Please see Appendix F of this document for a further description of the cultural competence program.

#### **X. Medical Integration/Coordination of Care**

Magellan recognizes the importance of integrating recovery and resiliency services with primary medical care. We recognize the important role in assisting customer organizations in their efforts to monitor and improve the quality of behavioral healthcare delivered in the primary care setting. There is continued emphasis on data collection in multiple topic areas and collaborative data analysis to identify opportunities for improvement when possible.

Core Components of the medical integration strategy, include:

- exchange of information with behavioral health, recovery/resiliency continuum and with primary care physicians
- provision of information/education to primary care physicians to promote appropriate behavioral health diagnosis and treatment and referral of behavioral health disorders commonly seen in primary care
- ensuring appropriate use of psychopharmacological medications
- management of treatment access and follow-up for enrollees with coexisting medical and behavioral disorders
- collaboration with DHS on quality improvement activities or prevention

#### **XI. Patient Safety**

The Iowa QI Program incorporates mechanisms to monitor patient safety. Core performance indicators, listed in the Work Plan, address elements critical to patient safety, including:

- Adverse incident reporting, tracking, and trending
- Accessibility of services for emergent and urgent care needs
- Consistency of application of medical necessity criteria
- Use of clinical practice guidelines
- Grievances per 1,000 members and turnaround time
- Appeals review and analysis
- Continuity and coordination of care
- Consumer satisfaction
- Provider compliance with treatment standards
- Provider compliance with administrative standards

The Iowa CMC's internal auditing mechanisms include elements critical to patient safety, including:

- Ambulatory follow-up implementation and monitoring
- Care manager documentation and observation

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- Clinical decision-making documentation
- Clinical practice guidelines implementation
- Grievance handling
- Coordination and continuity of care
- Intensive care management
- Consumer satisfaction
- Physician advisor documentation

The Iowa CMC creates an atmosphere among practitioners / providers in the Iowa Plan network in which the safety of Magellan's members is supported, including:

- Safety plan monitoring for inpatient facilities.
- Information on practitioner/provider participation in Magellan's quality improvement program in the Iowa Plan Provider Manual, including reviews of treatment plans, grievances, adverse occurrences, treatment records and site visits, PCP communication, application of Magellan clinical practice guidelines, adverse outcome reporting, and provider inquiry and review.

Magellan has a catalogue of patient safety activities, with definitions of services, directly related to patient's physical safety or to improvement of clinical care which reduces potential risks of harm to patients and others.

## **XII. Resources**

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

- the Analytical Services Department which provides the CMC with data reports on several QI and UM indicators and provides consultation on report definitions and analysis.
- the Network Services Department which supports the CMC by verifying the accuracy of credentials submitted by providers for inclusion in the network.
- the Corporate Outcomes/Evaluation & Research Department which supports the CMC by providing direction on the identification, implementation, and documentation of Quality Improvement Activities and by implementing satisfaction surveys for members, providers, and customer organizations.
- the Magellan National Clinical Management Department which supports the CMC through the development of policy and standards, QI document templates, medical necessity criteria, clinical practice guidelines, and consultation on clinical, medical, and quality issues for all care and condition care management programs that occur in the Iowa CMC.

The CMC senior management, service recipients and family members, healthcare practitioners, and representatives from service delivery systems participate in the QI and UM programs through participation in the local committee structure, which includes the Quality Improvement Committee, Professional Provider Review Committee, and related bodies.

The QI program is supported locally through design, implementation, analysis, and reporting of QI data. See Appendix D.

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**XIII. Minutes and Reports** Comprehensive, accurate, and timely minutes are prepared for each QI Committee meeting. These minutes reflect the date and duration of the meeting, the chairperson, and the members present and absent, and the names of guests. The minutes identify each topic or issue discussed with a summary of the discussion, conclusions drawn by the committee, and recommendations, actions or follow-up items. Applicable reports and data are appended to the minutes. All minutes are signed and dated by the committee chairperson following approval by the committee.

**XIV. Credentialing and Recredentialing**

The Network Department is responsible for provider credentialing and re-credentialing in accordance with customer policy and the Iowa Plan Provider Manual.

**XV. Annual Program Evaluation** The Quality and Compliance Director coordinates the development of the CMC quality improvement and utilization management program evaluation, which is a scheduled activity on the Quality Work Plan. The annual evaluation report will document the following:

- Title/name of each activity
- Goal and/or objective(s) related to each activity
- CMC departments or units and staff positions involved in the QI activities
- Description of communication and feedback related to QI data and activities
- Statement describing if goal/objectives were met completely, partially or not at all, and
- Actions to be taken for improvement
- Trends identified through QI activities and resulting actions taken for improvement
- Rationale for changes in the scope of the QI Program and Work Plan
- Review, evaluation and approval by the QI Committee of any changes to the QI Work Plan
- Necessary follow-up with targeted timelines for revisions made to the QI Work Plan.

**XVI. Confidentiality and Privacy/Medical Records and Communication**

The Iowa CMC recognizes the increased complexity of protecting patient's privacy while managing access to, and the release of, protected health information (PHI) about members. The Director of Operations and the Quality and Compliance Director are responsible for the creation, implementation and maintenance of privacy-compliance related activities. The QI Committee maintains copies of all committee minutes, reports, or other data in a confidential manner that will provide anonymity to providers, services recipients and family members. Access to these documents is available only to committee members, specific individuals as designated by the committee chair, members of the Magellan corporate committee structure, and to auditors authorized to review Magellan activities for the purpose of accreditation oversight due diligence. Minutes and reports are open to review by DHS and DPH as required by the Iowa Plan contract and by state and federal regulatory agencies, when required by law.

The Iowa CMC ensures the maintenance of behavioral medical records in accordance with policy and the Magellan Provider Manual. The QI Department periodically reviews compliance with medical record documentation through the application of a designated provider monitoring tool.

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**XVII. Amendments and Revisions.** The Iowa QI Program Description can be amended or revised at any time by the QI Committee. Major revisions must be approved by the NQC. Documentation for amendments or revisions can be found in the signed and dated QI Committee minutes.

**XVIII. Approval of Documentation**

The Iowa QI Program Description, QI Work Plan, QI Quarterly Reports, and Annual Quality Assurance Report (annual QI Program Evaluation) are approved initially by the QI Committee and are submitted for final approval to the NQC. Prior to submission to the NQC, the documents are signed and dated by the co-chairs of the QI Committee.

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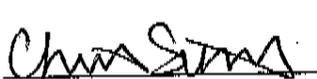
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**XIX. Signature Page**

This Iowa QI Program Description was approved by the Iowa Quality Improvement Committee during its meeting on *[insert date of meeting]* as indicated by the signatures below:

Signature:  Date: 7-16-08

Joan Discher, General Manager  
Co-chair person of Iowa QI Committee

Signature:  Date: 7-16-08

Chris Sims, Quality and Compliance Director  
Co-chair person of Iowa QI Committee

**Appendix A**

**Iowa Quality Improvement Committee Structure**

**Magellan Health Services /**

**Magellan Behavioral Care of Iowa**

**July 2008 – June 2009**

**Quality Improvement Program Description  
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## Iowa QI Committee Structure



**Appendix B**

**Magellan Corporate QI Committee Structure**

**Magellan Health Services /**

**Magellan Behavioral Care of Iowa**

**July 2008 - June 2009**

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for the  
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## MAGELLAN HEALTH SERVICES CORPORATE QUALITY COMMITTEE STRUCTURE

The Magellan quality program is operationally embedded. Quality program oversight and monitoring are accomplished through a network of quality committees reporting to the Enterprise Quality Council. Members, representatives from relevant medical delivery systems and practitioners are included in the quality committees through Advisory Groups at the business unit level. These mechanisms allow Magellan to obtain stakeholder input into planning, designing, implementing, monitoring, and revising the QI program and associated activities throughout the program year. The Magellan quality committee structure is described in the following section.

### *Enterprise Quality Council (EQC)*

#### A. Authority and Role of the EQC

The Enterprise Quality Council (EQC) is responsible for the quality improvement program of current and future Strategic Business Units (SBUs) and enterprise-wide functions. The EQC establishes priorities for the Quality Improvement Program, evaluates clinical and operational quality of care and services, oversees operational processes based on quality indicators and monitors performance improvement on an enterprise-wide basis. The Enterprise Quality Council meets, at a minimum, quarterly. The committee is chaired by the Chief Medical Officer. For efficiencies in oversight and monitoring the EQC has a network of committees, which are described in this document.

#### B. Functions of the NQC

- Oversee enterprise quality structures, processes and outcomes to meet goals of patient centric, safe, efficient, effective, timely and equitable healthcare.
- Monitor, through the functions of its sub-committees, performance improvement activities throughout the Magellan organization.
- Oversee the EQC committees in their processes to identify opportunities for performance improvement, perform root cause analyses and prioritize interventions
- Monitor enterprise-wide compliance activities including meeting external auditing requirements
- Identify potential areas of risk and monitor timely interventions
- Reassess activities continuously to determine whether optimal results have been achieved and sustained
- Promote sharing and exchange of best practices across enterprise units
- Recommend policy decisions, metrics, processes and procedures
- Oversee accreditation activities and projects
- Identify communication strategies for highlighting and advancing performance improvement
- **Provide annual report to the CEO and the Board of Directors.**

#### C. Composition of the EQC

- Chief Medical Officer (Chair)
- General Manager of NIA- Chair of NIA QIC
- Chief Medical Officer (BH)- Chair of BH QIC
- ICORE- Chair of ICORE QIC
- Chief Compliance Officer
- SVP Network Operations
- Operations delegate
- IT delegate

- SVP PR, Communications and Proposals
- SVP Quality & Outcomes (Co-Chair)
- SVP Clinical Standards and Practices

### **Subcommittees of the Enterprise Quality Council**

The committees of the EQC provide quality oversight of corporate functions and their respective business units' quality improvement programs including the: development and annual review of Program Descriptions and Work Plans; annual review of program activities; and quarterly reporting to the Enterprise Quality Council. The EQC sub-committees include:

1. National Imaging Associates Quality Improvement Committee
2. ICORE Quality Improvement Committee
3. Behavioral Health Quality Improvement Committee
4. National Network and Credentialing Committee
5. Compliance Committee

### ***Behavioral Health Quality Improvement Committee***

#### A. Authority and Role of the BH QIC

The Behavioral Health Quality Improvement Committee (BH QIC) has authority over the Magellan Behavioral Health Quality Improvement Program in order to promote and maintain meaningful, relevant and substantive improvements in company processes and results. The BH QIC meets, at a minimum, quarterly. The committee is chaired by the Chief Medical Officer- Behavioral Health..

#### B. Functions of the BH QIC

- Establish priorities for the quality improvement programs of Magellan Behavioral Health
- Review and assess overall priorities and trends with regard to company's continuous performance improvement including core performance indicators and company-wide QI initiatives.
- Identify "better practices" and monitor systematic implementation throughout the company, including effective mechanisms for communication, distribution and training.
- Review recommendations from external assessments and consultative initiatives as they pertain to quality improvement.
- Oversee annual policy and program description review and approval.
  - Review and approve the clinical criteria, *Magellan Behavioral Health Medical Necessity Criteria*.
  - Approve adoption and re-adoption of clinical practice guidelines (CPG) as recommended by the CPG task force.
  - Approve Technology Assessment Committee (TEC) recommendation
- Review Patient Safety Program activities and initiatives.
- Provide annual report to the CEO and the Board of Directors.
- Provide quality oversight and linkages with subsidiary company quality programs.
- Review compliance program activity reports relevant to behavioral health
- Review the quality program for the network of providers serving behavioral health members
- Review and approve annual CCM and ICM programs
- Oversee quality programs of the regional Care Management Centers

#### C. Composition of the BH QIC

- Chief Medical Officer- Behavioral Health (Chair)

- VP of Operations(Co-Chair)
- SVP, Clinical Operations
- SVP, Operations & Network Services
- Chief Clinical Officers
- General Manager, Condition Care Management
- VP/ Directors Quality Management
- National Director Quality & Accreditation
- Others as assigned by the Chair

### ***Behavioral Health Care Management Center Quality Improvement Committees***

The BH CMC Quality Improvement Committees have authority over the CMC Quality Improvement Programs and report to the BHQIC. The CMC QIC reviews reports from the CMC quality committees, establishes and maintains mechanisms to: review core performance indicators and other quality data, identify and prioritize opportunities for improvement, develop and/or monitor quality improvement interventions, and evaluate outcomes. In addition, the CMC QIC oversees the process by which practitioners/providers, members, and other relevant stakeholders have input into the QI program, through the CMC Member Advisory Group, CMC Provider Advisory Group, or member and provider membership on the QIC or other committees.

## **Appendix C**

### **Magellan Quality Improvement Process**

**Magellan Health Services /**

**Magellan Behavioral Care of Iowa**

**July 2008 - June 2009**

**Quality Improvement Program Description**

**for the**

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## **VI. QUALITY IMPROVEMENT PROCESS**

The quality improvement process is cyclical, and begins with development of an annual Work Plan, which includes core performance indicators and monitoring and intervention activities designed to improve the safety of members and the quality of care and services. Work plan goals are evaluated annually with achievements and opportunities for improvement specified.

### **A. Indicators, Performance Goals, and Monitoring Metrics**

Annually, the NQC defines, reviews, and updates core performance indicator definitions to reflect important aspects of care and services for Magellan covered populations, accreditation and regulatory requirements, and contracted services.

Performance goals are established based on previous monitoring experience, external data, contractual requirements, accreditation and regulatory requirements, and/or industry standards. Performance is measured and indicators that do not meet goal may be identified as opportunities for improvement within a region or across the company.

### **B. Quality Improvement Activities**

When opportunities for improvement are identified, interventions are developed and implemented. Interventions may occur as part of routine management activities, or, if complex, lead to development of a Quality Improvement Team (QIT). QITs include staff having direct or indirect impact on the targeted processes. The QIT performs a barrier or root cause analysis, prioritizes findings, and identifies and implements specific interventions to address each barrier or cause. Input from members, providers, and relevant medical delivery systems is obtained as appropriate.

Interventions are monitored to determine if they resulted in improvement. Unresolved opportunities for improvement move through the quality improvement process until satisfactory improvement is noted.

The process is documented in signed and dated committee minutes, QI reports, quality improvement activity reports, and/or the annual corporate QI Program Evaluation.

## **Appendix D**

### **Resources Allocated to QI Program**

**Magellan Health Services /**

**Magellan Behavioral Care of Iowa**

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**Appendix D**

**Magellan Health Services**

**Resources Allocated to Iowa QI Program**

**Quality Improvement Program**

<b>Iowa QI Staff</b>	
<b>Title</b>	<b>Percent of FTE Allocated to QI</b>
General Manager	15%
Medical Director	20%
Chief Clinical Officer	15%
Director Operations	15%
Director, Quality & Compliance	100%
Clinical Learning Lead	25%
QI Clinical Reviewers – Mental Health (3)	100%
Specialist, Quality Improvement	100%
QI Clinical Reviewer – Substance Abuse	100%
Specialist, Quality Improvement	45%
Administrative Assistant (2)	30%
Peer Specialist	10%
Consumer/Family Advocate	20%
Manager, Area Contracting	20%
Network Coordinator	20%
Managers, Clinical (2)	5%
Care Managers	5%
Manager, Administrative	20%
Follow-Up Specialist (5)	10%

<b>Corporate Staff</b>	<b>Percent of FTE Allocated to QI</b>
Senior Vice President, Quality Improvement	15%
Vice President Quality Improvement	30%
National Director, Quality Improvement	30%
National Director, Quality & Accreditation	20%
Vice President, Outcomes & Evaluations	10%
Vice President, QI Performance Measurement	10%

*[fill in your own CMC Technical and Analytical Resources below- see example from one CMC as a reference]*

<b>Technical Resources</b>
<b>Clinical Information System</b>
AMSW – LOCAT, ASAM
<b>Claims System</b>
CAPS
<b>Eligibility/Authorization System</b>
AMSW
<b>Other Technical Resources</b>
<i>Microsoft® Office Suite</i>
<i>Provider Stand Alone Search</i>
<i>Visio® Basic</i>

<b>Analytical Resources</b>
<b>Staff backgrounds in:</b>
Computer programming
Healthcare data analysis
Research methodology
Healthcare data analysis
<b>Commercial Statistical Analysis Programs</b>
<i>Access</i>
<i>Excel</i>
<i>GeoNetworks®</i>
<i>SAS</i>
<i>SPSS</i>

Analytical Resources
<b>Customized Programs Available</b>
Ambulatory Follow-up Report
Compliments, Complaints, Grievances
HEDIS 3.0
Member Satisfaction Survey System
Monthly IUR Summary Report
Practitioner Profiling Report
Practitioner Satisfaction Survey System
Readmission Report

**Appendix E**

**Utilization Management Program Description**

**Magellan Health Services /**

**Magellan Behavioral Care of Iowa**

**July 2008 - June 2009**

**Quality Improvement Program Description**

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## **Magellan Health Services – Iowa Care Management Center**

**2008**

### **UTILIZATION MANAGEMENT PROGRAM DESCRIPTION**

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### Section II: Structure and Resources

#### **Introduction**

The Magellan Health Services (Magellan) Utilization Management (UM) Program Description is a descriptive outline that conveys Magellan's care management activities, including UM functions, scope, goals, structure and resources. This document, along with Magellan's policies are used to provide a comprehensive view of Magellan's care management program.

Care management activities described in this document contribute to providing prompt attention to meeting the individual member's<sup>1</sup> clinical needs, cultural characteristics, safety and preferences by an appropriate provider<sup>2</sup> within a timeframe reflecting the clinical urgency of the individual member's situation.

#### **Magellan Vision and Mission**

Magellan's vision is "To use our behavioral health expertise to improve health outcomes for individuals and families fighting illness, needing counsel or seeking other support with life's challenges." The following mission has been established to support our vision:

"We maximize the power of our behavioral health expertise to support individuals and families at the most sensitive moments of their lives. We deliver trusted and innovative solutions to our customers and collaborate with our providers to positively influence individuals' total health and well-being and increase value for all of our stakeholders."

#### **Care Management Philosophy**

It is a patient centric approach that directly benefits members by attaining the highest degree of value from the available behavioral healthcare delivery system and development of proactive guides or predictors for designing care management and behavioral health treatment strategies. It is with this approach that sustained positive treatment gains through optimal behavioral health resources utilization is achieved. Fundamental tenets of this care management philosophy are: (1) consideration of individual member factors; (2) a highly accessible care delivery system; (3), a network of providers that meet credentialing requirements; and (4) clinically sound, research-based decision making tools to promote utilization of appropriate behavioral health care resources in an efficient and effective manner.

Care management activities and goals described in the UM program interface with Magellan's QI program through the QI Work Plan which includes monitoring and evaluation of care management goals, UM functions and activities

The following principles developed in accordance with the most current scientifically based health care research available guide staff engaged in care management activities:

- Individuals in need of behavioral health services have access to the full continuum of care.
- A member's treatment is always guided by an individual treatment plan.
- Clinically necessary treatment occurs in the least restrictive environment that is available, safe, and clinically appropriate.
- Discharge planning of timely, clinically appropriate aftercare is an essential provision for the continuum of care that begins at the time of acute inpatient admission.
- Timely ambulatory treatment for behavioral health disorders contributes to expedient symptom reduction.
- Member's behavioral health needs are addressed utilizing available community behavioral health resources and EAP services.

<sup>1</sup> Members refer to population covered by Magellan that have accessed or are accessing behavioral health services.

<sup>2</sup> Provider is a global term used by Magellan to represent individual practitioners, programs, or facilities that are licensed, certified or qualified to render direct behavioral healthcare services.

### Section II: Structure and Resources

- Coordination of care includes sharing of timely relevant clinical information between behavioral healthcare and medical care as necessitated by the member's health needs. This information exchange is done with appropriate respect for privacy and consistent with all Magellan policy and applicable laws governing patient confidentiality.

Magellan does not reward, financially or through other mechanisms, employed or contracted personnel who perform clinical review process functions to render determinations that would deliberately result in inappropriate utilization of care and/or services, especially under-utilization of services. Medical necessity decision making is based on appropriateness of care and service as well as available and applicable benefits. A statement containing the above points is provided to employees and contracted personnel at hire or initial contracting. This position is also communicated to members, as allowed by contract, and providers via manuals and/or newsletters<sup>3</sup>.

#### Scope

The scope of the care management activities described in this document includes: accessing Magellan services, intake, triage and referral; clinical review of requested behavioral health services; appeal processing; transition/aftercare care coordination; processes to support preventative care and coordination with medical services; development, review and usage of clinical decision support tools; and assessment of new procedures, treatments and technology in behavioral health treatment.

The above UM functions and activities were designed to align with Magellan's care management philosophy and support optimal and appropriate utilization of behavioral health resources within available behavioral health services including acute inpatient, non-acute/sub-acute inpatient (i.e. rehabilitation or care provided in residential treatment centers), intermediate ambulatory (partial hospitalization or intensive outpatient), routine ambulatory (i.e. traditional outpatient), as well as other settings such as home care, mobile evaluation/treatment, supervised living, and employee assistance programs (EAP).

Magellan's provider network development includes credentialed behavioral healthcare practitioners and organizational providers (facilities and programs) with a wide range of expertise and representation from each of the behavioral healthcare clinical subspecialties. Available behavioral health treatment services covering existing behavioral health levels of care are contracted with and available to covered members consistent with their benefit plan. Magellan has developed guidelines for density and geographic distribution of behavioral health providers, based on the membership and distribution of the covered populations.

Activities supporting the UM program's scope at the corporate level include:

- Develop and update as needed, policies associated with care management activities and the *Magellan UM Program Description*.
- Evaluate Magellan's UM program effectiveness and effect on members and providers as well as achievement of corporate UM program goals via the annual QI program evaluation.
- Review, solicit provider input, and update clinical review and decision support tools such as medical necessity criteria and adopted clinical practice guidelines.
- Develop and implement new technology assessment process and criteria.
- Develop performance standards, indicators and goals for care management activities.

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<sup>3</sup> Includes web access as well as paper versions.

### Section II: Structure and Resources

- Review performance data associated with UM program and make recommendations regarding the methodology, analysis, findings, action plan implementation and results of actions.
- Develop standards for clinical staff qualifications as well as role and functions, in accordance with federal, state and customer regulations/requirements or standards.
- Establish and maintain an organizational structure that allocates resources to support implementation and oversight of the activities in the UM Program.
- Oversee development/implementation of Care Management Center (CMC) UM programs and related policies.

Activities supporting the UM program's scope at the Care Management Center<sup>4</sup> (CMC) level include:

- Update, customize as needed, and implement CMC UM program and related policies to meet population needs, community standards, client contractual obligations, and state laws.
- Review, update, solicit regional provider input and approval as needed for medical necessity criteria.
- Adopt at least two (2) Magellan approved clinical practice guidelines.
- Solicit regional/local provider and member input for various UM Program activities.
- Inform members (as allowed), providers and customers of CMC UM program effectiveness and effects as required by policy, regulatory agencies and/or accreditors.
- Participate in QI activities and core performance indicators designed to monitor and evaluate the overall impact and effectiveness of the UM program including an annual evaluation of behavioral health resource utilization.
- Evaluate care management activities for their effect on members and providers on an annual basis.

#### **Confidentiality**

Magellan safeguards member information and makes disclosures only in accordance with federal regulations (such as HIPAA), state law, as well as industry standards and professional ethics. Protected health information (PHI) collected and recorded as part of care management activities are appropriately safeguarded and held in strictest confidence by any employee of Magellan whose duties require knowledge of, and access to this information. Clinical information used in proceedings, records, writings, data, or reports for UM committee review are presented with PHI removed. Magellan has multiple policies in place that describe the standards for confidentiality of protected health information.

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<sup>4</sup> Care Management Centers are locations that serve accounts or customers with membership limited to a specific geographical location or as a national service center for accounts with membership without geographical boundaries that may span across several regions or an entire country.

#### Section I: Overview of Program

##### ***Iowa CMC UM Program Goals 2008***

1. Better customer service
  - a. Increase live call transfer to a care manager to reduce call backs
  - b. Individualized pre coded notes to spend more clinical time on members that may benefit from community-based alternatives.
  - c. Integrate recovery/resiliency language into pre coded notes.
2. Improve member outcomes with behavioral and health conditions
  - a. Intervene with referral for mental health services.
  - b. Use PHQ-9 and outcome data for measurement.
3. Meet Iowa performance incentives
  - a. 7 day follow up for mental health inpatient at 90%, 14 day follow up for residential substance abuse at 60%
  - b. Inpatient readmission at 15%
4. Achieve readmission rates for inpatient to 10% with increased psychiatric in home nursing and Intensive Care Management interventions
5. Increase use of Peer Support and WRAP
  - a. Program development by Peer Specialist
6. Integrate at least one Magellan Clinical Practice Guideline into daily care management practice
  - a. Develop tip sheet for daily care management use.

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#### Section II: Structure and Resources

### Section II: Structure and Resources

#### ***Board of Directors and National Quality Council***

The Magellan Board of Directors has the ultimate authority and responsibility for the quality of behavioral healthcare and service delivered to members of its customer organizations. The Board of Directors designates the National Quality Council (NQC) to have broad oversight of the Magellan quality improvement program.

#### ***Corporate UM Committee***

***Role: The Corporate UM Committee has authority for the approval as well as oversight of the UM program implemented at each CMC.***

#### ***Functions:***

- Review, revise as needed, and approve the Magellan UM Program, goals and related policies on an annual basis.
- Review and approve a formal annual evaluation of the Magellan UM Program contained within the Magellan QI Program Evaluation.
- Recommend actions as needed to address aggregate and trended work plan performance monitoring and core performance indicator results.
- Review and approve the adoption of *Magellan Behavioral Health Medical Necessity Criteria*.
- Provide input for clinical practice guidelines (CPGs) as recommended by the CPG task force.
- Oversee the process of new technology assessment.

***Structure: Meeting frequency: The Corporate UM Committee meets at least six (6) times a year.***

*Membership*<sup>5</sup>: Standing members of the Corporate UM Committee include:

- Senior VP Clinical Operations (chair)
- Strategic Business Unit (SBU) Chief Clinical Officers
- Strategic Business Unit (SBU) VPs Clinical Operations
- Senior VP Medical Services
- Senior VP Quality Improvement
- Director, UM Projects

**Reporting:** The Corporate UM Committee reports major actions and accomplishments to the National Quality Council (NQC). Other corporate committees and CMC level management are provided with relevant key discussions, recommendations and actions. The Senior VP, Clinical Operations or designee maintains the original signed approved meeting minutes. On-line copies for internal distribution contain the notation “signature on file” and the date of approval.

#### ***Care Management Center (CMC) UM Committee***

Each CMC has an independent UM Committee or standing UM agenda items integrated within its Quality Improvement Committee (QIC). The activities of the various CMC committees support operating procedures that are designed or customized at the CMC level to address customer requirements, regional standards and unique membership needs of that CMC or account.

<sup>5</sup> Staff titles indicated in membership listing are current at the time this document was approved. Position titles and/or responsibilities may be changed by executive leadership to support the mission and goals of the organization.

### Section II: Structure and Resources

**Role:** Each CMC UM Committee or UM component within its QIC has authority for implementation and monitoring the effectiveness and effect on its membership of the CMC UM program(s)<sup>6</sup>.

**Functions:**

- Annually develop, update and approve a CMC UM program.
- Annually review, customize as need, approve and implement policies and procedures that are associated with the scope and activities of the UM program.
- Annually review, approve and implement use of *Magellan Behavioral Health Medical Necessity Criteria* or customer specified clinical review criteria.
- Review, approve and implement at least two clinical practice guidelines adopted by Magellan.
- Review findings, trends and implementation of recommended interventions of QI Work Plan performance monitoring related to care management activities described in the core performance indicators on at least an annual basis.
- Evaluate the CMC UM program's effectiveness at least annually and document within the CMC QI program evaluation.
- Develop, revise and implement processes for meeting requirements of applicable accreditation, delegation and regulatory surveys (e.g. NCQA and AAHCC/URAC).
- Develop and periodically revise as needed CMC thresholds established for the quantitative and qualitative evaluation of optimal behavioral health resource utilization (under or over utilization) in relation to experience, member characteristics, behavioral healthcare delivery network characteristics and customer requirements.
- Solicit provider and member input via CMC Member and Provider Advisory Group forums for recommendations related to UM program.
- Forward requests or make requests for relevant for New Technology Assessment process to Corporate Medical Services.
- Oversee and monitor all delegated UM functions as applicable.

**Structure: Meeting frequency:** CMCs with an independent UM Committee meet at least every other month. If the CMC integrates UM within its QIC, the frequency of specific UM agenda items are determined by the CMC in order to meet fulfilling all UM committee functions annually.

**Membership<sup>7</sup>:** Standing members of an independent CMC UM Committee are:

- Vice President Clinical Services (Co-chair)
- Vice President Medical Director (Co-chair)
- QI Director
- President or operations representative as designated by the President

**Reporting:** If the CMC UM Committee is independent it provides regular reports to the CMC QI Committee as to its actions and accomplishments on a frequency determined by the CMC QI Committee. The VP Clinical Services or designee at the CMC office maintains the original signed approved meeting minutes.

### *Corporate Structure and Resources that Support the UM Program*

<sup>6</sup> A CMC with multiple customers (accounts) may have more than one UM program description in place.

<sup>7</sup> Staff titles indicated in membership listing are current at the time this document was approved. Position titles and/or responsibilities may be changed by executive leadership to support the mission and goals of the organization.

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### Section II: Structure and Resources

The responsibility for day-to-day operations of the UM Program is under the leadership and direction of the Chief Medical Officer and Senior VP, Clinical Operations. In collaboration with other executive management, the executive leadership for the UM program ascertains that the UM Program goals are strongly aligned with Magellan's corporate mission, values, goals and objectives.

Each Strategic Business Unit (SBU) Chief Clinical Officer and VP Clinical Operations is also charged with providing on-going oversight and guidance with CMC UM program activities, policies and initiatives.

#### ***CMC Structure and Resources that Support the UM Program***

CMC UM operations are directed by the CMC senior clinical and medical management team. The CMC President has oversight responsibilities for all day-to-day operations including care management activities.

A Medical Director and Clinical Services VP and/or Director lead and have oversight over the implementation of UM program functions such as triage, referral and clinical review as well as other UM program activities carried out at the CMC level. Oversight includes, but is not limited to monitoring consistency of medical necessity determinations and involvement in clinically complex cases. Medical Directors are licensed psychiatrists who meet Magellan's experience qualifications. Clinical Services VPs are doctoral level clinical psychologists and meet Magellan's experience qualifications.

Supervision duties including, but not limited to, monitoring consistency of clinical/medical necessity criteria application and compliance with documentation standards, are also conducted by the Medical Director and Clinical Services VP and/or Director.

#### **Core Staff to Support UM Program**

Resources are allocated and configured in a variety of ways to support the implementation of care management activities which best meet the clinical and cultural needs of the CMC's member population and to comply with contract or state law. Each CMC has authority to hire staff as well as monitor staff performance. Magellan's corporate Human Resource Department establishes core competencies and qualifications for all positions with input from corporate leadership in various functional areas.

CMC senior leadership is responsible for meeting local/regional regulations and corporate as well as customer requirements for UM program resources and operations.

Orientation, training and professional development of care management staff and clinical leadership at the CMC level is conducted by designated CMC staff and the corporate clinical training department. Clinician/Physician Advisors and CMC medical leadership receive training through the Medical Services department.

Non-clinical care management support staff receive training and mentoring related to their assigned duties as well as in computer systems, customer interface and important aspects of behavioral health and its delivery system.

#### ***Customer Service Associate (CSA)***

CSAs perform administrative non-clinical functions. A bachelors degree (or equivalent) in psychology, social services or healthcare is preferred, with previous experience in healthcare or a customer service environment.

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### Section II: Structure and Resources

#### *Follow-Up/Aftercare Specialist*

Follow-Up/Aftercare Specialists provide administrative assistance to Care Managers with establishing aftercare plans, verification of aftercare service attendance and outreach to members' transitioning to aftercare behavioral health services following an acute inpatient stay. This activity is designed to support treatment gains achieved during inpatient treatment.

#### *Care Manager (CM)*

Care Managers perform core UM program functions of triage, referral, first level clinical review and case management. CMs have authority to approve services requested based on benefits, contract requirements and explicit clinical/medical necessity criteria. Care Managers are licensed behavioral healthcare practitioners (RN, master's level or doctoral level).

#### *Clinician Advisor (CA)*

Clinician Advisors can perform peer or second level clinical reviews and appeal reviews for ambulatory care cases where the attending/treating practitioner is a social worker, psychologist or registered nurse practitioner. CAs render medical necessity determinations. Clinician Advisors are licensed doctoral psychologists with appropriate specialty and sub-specialty training.

#### *Physician Advisor (PA)*

Physician Advisors perform peer or second level clinical/medical necessity review and appeal reviews. PAs render medical necessity determinations. Physician Advisors are licensed board-certified psychiatrists or board certified in a specialty other than psychiatry and with additional background and training in substance abuse/addictions treatment.

### Section III: Care Management Activities

#### **Accessing Magellan Services**

Magellan's services are accessible 24 hours a day, seven days a week, throughout the entire year. Members<sup>8</sup> or providers can access services via phone or in writing. Performance standards are established for telephonic access for intake (screening) and triage. Guidelines describing communications of UM processes and issues between Magellan and members and providers are also in place.

*Policies: Accessibility of Service and Care  
Preauthorization and Concurrent Review of Treatment Services*

#### **Intake**

When a member seeks access to behavioral health services or a provider initiates a treatment authorization, a CSA verifies the member's eligibility and routes the call to a CM for triage and referral. If a member appears to be in crisis, eligibility is verified after the CSA routes him/her to a CM for immediate intervention.

For non-crisis member inquiries, CSAs with appropriate experience, knowledge, and supervision, may link members to preferred network providers by providing names and locations of one or more those providers.

When a member is not eligible for services per their contract, the CSA informs the caller, documents the absence of coverage and refers the member to a CM or appropriate person(s) within the customer health plan for further assistance. If a member's behavioral healthcare benefits have been exhausted or the member's provider has terminated from the network, the member is referred to a CM for assessment and appropriate actions as determined by the member's clinical needs and available resources.

*Policies: Accessibility of Service and Care  
Coordination of Care When Benefits are Exhausted  
Transfer of Member Care Due to Provider Termination  
Triage and Referral*

#### **Triage and Referral**

A clinical member of the Magellan care management team conducts an initial telephonic assessment with a member to obtain information that forms the basis for:

- determining the level of urgency for treatment services (emergent, urgent or routine care);
- the level of care needed to promote the effectiveness of behavioral health;
- the medical necessity of behavioral health conditions; and
- the provider characteristics suited to meet the individual needs or preferences of each member.

The assessment data are used to determine a best match between a member's needs, preferences, and a network<sup>9</sup> provider's expertise. This assessment does not substitute for a face-to-face diagnostic evaluation. The CM determines the level of clinical urgency for timeliness of appropriate evaluation and treatment services and actively facilitates the member obtaining services when the clinical urgency is emergent or urgent. Clinical urgency is defined as follows:

*Non-life threatening emergency* is a condition that requires rapid intervention to prevent acute deterioration of the member's clinical state or condition. Gross impairment of functioning usually

<sup>8</sup> Members include member's authorized representative or legal guardian.

<sup>9</sup> Refers to an appropriately credentialed provider.

### Section III: Care Management Activities

exists and is likely to result in compromise of the member's safety. Interventions are required within six (6) hours and should include a face-to-face evaluation.

*Urgent* is a situation that is less clinically compelling than an emergent situation and the member's clinical condition would likely deteriorate without intervention. A member assessed as needing an urgent level of care is seen within 48 hours of the call.

*Routine* is when the member's condition is considered to be sufficiently stable and not to have a negative impact on the member's condition to allow for a face-to-face assessment to be available within ten (10) business days following the request for service.

Referrals are based on the member's clinical features, needs and preferences as reported by the member or member representative. This information is used together with a provider's expertise and availability. Emergency services are available to members as necessary for screening and stabilization. Specifics regarding coverage of emergency services related to prudent layperson and authorized representative is covered in the *Review of Emergency Services for Payment* policy.

<i>Policies</i>	<i>Accessibility of Service and Care</i>
	<i>Availability of Providers</i>
	<i>Review of Emergency Services for Payment</i>
	<i>Triage and Referral</i>

#### ***Clinical Review of Requested Behavioral Health Services***

Principles of clinical review are guided by Magellan's patient centric care management philosophy and clinical review criteria in order to best meet the bio-psycho-social needs of the member.

#### Clinical Information

Clinical information collected as part of clinical review is gathered by CMs and/or Clinician/Physician Advisors to assess the clinical urgency of situation and perform clinical review of requested services. Magellan has standards in place to promote consistency of clinical information collected and documented as part of the clinical review process. Applicable confidentiality laws, regulations and requirements are always applied to the following core clinical information documentation standards:

- presenting problem (situation and/or symptoms)
- mental health treatment history including medication(s)
- substance use treatment history
- medical history including medication(s) and current treatment regimes
- mental status (as reported by a practitioner)
- risk potential
- current support systems and
- diagnosis (as reported by a practitioner)

Subsequent concurrent clinical reviews for continuing treatment services also require consistent and comprehensive documentation of information gathered from the attending/treating provider in the following areas:

- consistency of diagnosis and treatment
- use of medication
- risk assessment
- comparison to standards of practice
- frequency/duration of treatment
- summation of progress and medical necessity
- discharge/aftercare plan

### Section III: Care Management Activities

Clinician/Physician Advisors document their medical necessity determinations by citing the specific medical necessity criteria and the clinical justification for their determinations.

#### Clinical Review Criteria

Medical necessity criteria<sup>10</sup> form the fundamental clinical review decision support tool applied to determine the medical necessity and clinical appropriateness of recognized levels of behavioral health treatment services. The approved medical necessity criteria are documented in the *Magellan Behavioral Health Medical Necessity Criteria*. Other clinical review decision support tools, such as adopted clinical practice guidelines are used as an adjunct to assess the quality of care and treatment appropriateness of requested services. Evaluation of the severity of need and intensity of service using the medical necessity criteria is uniformly applied by clinical review staff to the clinical information obtained.

The *Magellan Behavioral Health Medical Necessity Criteria* contains criteria for the following BH care service settings:

#### *Hospitalization*

The highest level of skilled psychiatric and/or substance abuse services provided in a facility licensed at the hospital level and provide 24-hour medical and nursing care. This criteria set includes crisis and 23-hour beds that provide a similar, if not greater, intensity of medical and nursing care.

#### *Residential Treatment Center*

Medically monitored, with 24-hour medical availability and 24-hour onsite nursing services provided 24-hours a day for persons with long-term or severe mental disorders and persons with substance related disorders. Rehabilitative treatment is included. Settings that are eligible for this service level are licensed at the residential intermediate level or as an intermediate care facility (ICF).

#### *Supervised Living*

Combines outpatient treatment on an individual, group and/or family basis (usually provided by off-site practitioners) with assistance and supervision in managing basic day-to-day activities and responsibilities outside the patients home. These settings are often residential in nature which provide supervision and other specialized custodial services such as halfway house, group home or community-based assisted living.

#### *Partial Hospital*

Defined as structured and medically supervised day, evening or night treatment programs and occur in a non-residential ambulatory setting. Program services are provided to patients at least 4 hours/day and are available at least 3 days/week, although some patients may need to attend less often.

#### *Intensive Outpatient Programs*

Intensive outpatient program or IOP is defined as having the capacity for planned and structured service provision of at least 2 hours/day and 3 days per week although some patients may need to attend less often. Services in an IOP would include multiple or extended treatment rehabilitation/counseling visits or professional supervision and support.

#### *Outpatient treatment*

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<sup>10</sup> May be referred to as clinical review criteria.

### Section III: Care Management Activities

Typically individual, family, and/or group psychotherapy and consultative services ranging in time from fifteen minutes (i.e. medication check-up) to 50 minutes (i.e. individual, conjoint, family psychotherapy) up to 2 hours (i.e. group psychotherapy).

While *Magellan Behavioral Health Medical Necessity Criteria* will assign the most safe and effective level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. Clinical judgment consistent with the standards of good medical practice will be used to resolve these exceptional cases

#### Process

The clinical review process is conducted according to federal/state regulations, contract requirements and accreditation requirements. Network providers are notified of the clinical review process via the *Magellan Behavioral Health Provider Handbook*. The clinical urgency of the situation determines whether the process will be expedited or standard. This process includes behavioral health services requested preauthorization (pre-service), concurrent or retrospective (post-service) to care being rendered and may include review by a CM and/or Clinician/Physician Advisor. Generally, a member or a member's authorized representative initiates the request for services; however, Magellan care management team may initiate the concurrent review process.

#### Iowa CMC UM Timeliness Standards

Intake 24 hour service or partial hospital	Calls for expedited requests taken live by care manager Standard requests processed within one hour of call *expedited requests are patients waiting for authorization of a inpatient hospital service to be admitted.
Concurrent 24 hour service and other telephonic service requests	One business day
Outpatient paper requests	5 business days

A CM involved in the clinical review process applies the medical necessity criteria against the clinical features of the individual as reported by a member or attending/treating provider and the evaluation/treatment setting resources available within the local behavioral healthcare delivery system. Following this review the CM may authorize the services requested or refer the request to a Clinician/Physician Advisor for a medical necessity determination if the requested service does not appear to meet medical necessity criteria, or other concerns about the quality or appropriateness of care are identified.

The Clinician/Physician Advisor reviews all available clinical information using their clinical knowledge and experience and applies the medical necessity criteria. Other clinical review decision support tools may be referred to when indicated, to render a medical necessity determination. A telephonic review with the attending/treating provider is always attempted by the Clinician/Physician Advisor to render and communicate a medical necessity review that may result in a non-authorization determination as part of a preauthorization or concurrent clinical

### Section III: Care Management Activities

review. The attending/treating provider is expected to comply with a telephonic peer review in a timely manner per his/her contractual requirements. When the treating/attending provider had not complied with a telephonic review prior to a medical necessity determination resulting in a clinical non-authorization determination, the treating/attending provider is notified of a Clinician/Physician Advisor's availability to discuss the medical necessity determination.

#### Determination

All decisions regarding member care are made by the attending/treating provider, who is encouraged to make treatment decisions in the best interest of the member independent of insurance coverage.

*Medical necessity determinations* are decisions regarding the medical/clinical appropriateness (i.e. the least restrictive level of care necessary to provide safe and effective treatment to meet the individual member's bio-psycho-social needs) of requested services based upon information provided by the attending/treating provider, facility, program, and/or the member.

*An authorization or non-authorization determination* whether it is *administrative* or *clinical* is a recommendation for plan benefit reimbursement of treatment services based upon the benefits available to the member and the medical necessity determination (when applicable).

#### Notification

The member, attending/treating provider, and applicable facility and/or programs are given verbal and/or written notification of a determination within prescribed time frames. When verbal notification is appropriate it is communicated to the member or treating/attending provider on behalf of the member. An authorization specifies the treatment setting, the number of visits/days and a time period as applicable. The notification of a non-authorization determination contains the reason for the determination, including the specific medical necessity review criteria, and/or benefit provision as well as information about the appeal process and the availability of an expedited appeal as applicable to the clinical urgency of the situation.

#### Timeliness of Determination and Notification

Timeliness requirements for rendering a determination and notification of the determination to appropriate parties are dictated by the clinical urgency of the situation as evidenced by the clinical needs of the member at the time of request, federal regulations, state laws and/or customer requirements. Magellan is committed to conducting clinical reviews in a timely manner and with minimal disruption to the provision of behavioral healthcare services to members and their families. Administrative requirements are designed to be minimal and not create barriers to care or service. Determinations are governed by policy with prescribed timeliness standards and routine monitoring for performance.

<i>Policies:</i>	<i>Administrative Determinations Appropriate Services and Care Based UM Decision-Making Care Management Clinical Documentation Preauthorization and Concurrent Review of Treatment Services Retrospective Review of Treatment Services</i>
<i>Other:</i>	<i>Magellan Behavioral Health Medical Necessity Criteria 2004, 2008</i>

#### **Clinical Appeal**

Members, member's authorized representatives and providers are entitled to appeal both administrative determinations of contracted services (administrative appeals) and medical necessity determinations resulting in a clinical non-authorization (clinical appeals). Available

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### Section III: Care Management Activities

appeal rights and process is communicated in the non-authorization determination and the appeal decision notification.

(Please note: Magellan appeal process are revised as necessary for specific customer requirements. For example, the Iowa CMC appeal process applies to both clinical and administrative appeals and has one level internal to Magellan prior to access to the State Fair Hearing process, consistent with the requirements of the federal Balanced Budget Act.) A Clinician/Physician Advisor who conducts the first or second level clinical appeal reviews may not have had prior involvement in the case under review nor be the direct report of the prior review Clinician/Physician Advisor.

The clinical urgency of the situation at the time of the appeal request determines whether the appeal will be conducted using the expedited or standard process.

#### Levels

The number (referred to as levels) of clinical appeals that are delegated to Magellan as well as levels made available by the customer organization are dictated by federal regulations, state laws and/or customer requirements.

#### Process

Initially the appeal request is determined for eligibility, the appeal request been made within the specified timeframe and appropriate processing timeframe, either expedited or standard.

The Clinician/Physician Advisor reviews the available clinical information as well as any additional information submitted by the member, attending/treating provider and facility/program for consideration. If the process is expedited the Clinician/Physician Advisor is expected to attempt to confer telephonically with the attending/treating provider prior to rendering an appeal decision that would result in upholding the initial non-authorization determination.

#### Decision

Appeal decisions are based on *medical necessity determinations* regarding the medical/clinical appropriateness of requested services based upon information provided by the attending/treating provider, facility, program, and/or the member.

An appeal decision can be either to uphold or overturn (whole or partially) the initial clinical review *non-authorization determination*. Clinical appeal decisions of medical necessity determinations are recommendations for plan benefit reimbursement of treatment services based upon clinical information provided by the member and/or the provider. All decisions regarding the member's care are made by the treating clinician, who is expected to make these decisions in the member's best interest.

#### Notification

The member, attending/treating provider, and facility or program is given verbal and/or written notification of an appeal decision within prescribed time frames. When verbal notification is appropriate it is communicated to the member or treating/attending provider on behalf of the member. The communication of the appeal decision includes, but may not limited to:

- the appeal decision;
- the title of the Magellan Clinician/Physician Advisor rendering the medical necessity determination;
- procedures for the next level of appeal, if applicable;
- the member's right to submit information for consideration as part of the appeal process;
- instructions for requesting written statements of clinical review criteria used to make non-authorization decisions.

#### Timeliness of Decision and Notification

**Section III: Care Management Activities**

Timeliness requirements for issuing an appeal decision and notification of the decision to applicable parties are dictated by the clinical urgency of the situation as evidenced by the clinical needs of the member at the time of the appeal request, federal regulations, state laws and/or customer requirements.

In some contractual relationships, the customer company/insurer may retain responsibility for one or all levels of appeal or may require an appeal level to be conducted by an external utilization review organization or independent review organizations (IRO). External review organizations are contracted with, referred to, managed and monitored as contractually required and follow applicable state/regional regulations.

<i>Policies:</i>	<i>Clinical Appeals</i>
<i>Other:</i>	<i>Magellan Behavioral Health Medical Necessity Criteria 2004, 2008</i>

**Coordination and Continuation of Treatment Along the Behavioral Healthcare Continuum**

**Discharge/Aftercare Planning:** Once a member is discharged from a level of care or completes a treatment episode, the CM promotes the consolidation and maintenance of treatment gains through oversight of the aftercare plan. Discharge planning is initiated when an inpatient episode begins so that when discharge occurs, the appropriate treatment authorization is already completed, allowing the patient an uninterrupted transition to an appropriate level of care. The CM is responsible for coordinating the referral and authorization between levels of care. The CM or Follow-Up/Aftercare Specialist performs and documents tracking the member's compliance with aftercare referral and outreach to non-compliant members as applicable.

<i>Policies:</i>	<i>Discharge Planning and Aftercare Monitoring</i>
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**Intensive Care Management (ICM):** Each CMC establishes an ICM Program to maximize positive clinical outcomes for identified cases to facilitate a well integrated, proactive care management plan. ICM may incorporate a variety of care management mechanisms including field care management programs. Each CMC selects criteria for the identification of cases, particularly at risk in their population, to:

- assist patients in navigating the service delivery system;
- coordinate available resources along the behavioral healthcare continuum;
- facilitate access to an appropriate array of services; and
- tailor care management intervention to the individual member needs.

<i>Policies:</i>	<i>Intensive Care Management Program</i>
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**Coordination and Continuity of Behavioral Healthcare Services and General Medical Care**

Magellan promotes the integration of behavioral health services with general medical services in keeping with the needs of our members, our client health plans and/or our state agency or employer clients in the context of the benefit contracts under administration. These activities are formally articulated in a medical integration plan and within policies that address the following critical areas:

- timely and confidential exchange of information throughout the treatment continuum;
- timely communication with primary care practitioners;
- review of medical and behavioral healthcare pharmacy benefits and formularies;
- collaboration with medical providers to increase appropriate use of psychotropic drugs; and
- evaluation of access, continuity, coordination and follow-up to medically necessary services within the behavioral healthcare and general medical communities.

<i>Policies:</i>	<i>Integration of Behavioral Healthcare with General Medical Care</i>
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**Section III: Care Management Activities**

*Medical Integration Plan*

***Coordination of a Member's Care Transition when Benefits are Exhausted***

Care Managers work closely with network providers in order to be prepared for a situation where benefit limits have been maximized and hence, reimbursement is no longer available. In accordance with accepted professional guidelines and standards for clinical practice, members in active treatment are never abandoned. Rather, appropriate policies are in place to support the safe transition of each member from one provider to another under a different benefit plan, private pay or publicly funded arrangement.

*Policies: Coordination of Care When Benefits are Exhausted*

***Coordination of Member's Care Transition due to Provider Termination from the Network***

Magellan promotes continuity of care when a provider terminates from the network by providing timely assistance to members in securing a transfer to an appropriately credentialed provider and addressing individual clinical needs which arise from the transfer. A transition period is offered to members when continuation of treatment with the provider creates no imminent danger. If imminent danger to the member is deemed to exist and supported by the findings of the CMC review process, the member is transferred to an appropriately credentialed provider within a time frame appropriate to the clinical urgency of the situation. The care management team works collaboratively with the departing provider to develop a clinically appropriate transition plan and identification of a new provider. Members may be referred to the ICM program, if their clinical condition warrants, in an effort to provide support and stability during the transition. Written notification with specifics about the transition plan is sent to members actively in treatment with the provider who terminates from the network.

*Policies: Intensive Care Management  
Transfer of Member Care Due to Provider Termination*

***Extra Contractual Benefits Eligibility and Management (ECB)***

Management of extra contractual benefits allows the care management team to provide specialized planning for behavioral health care treatment on a case-by-case basis to meet the unique clinical and cultural needs of members. The intention is to maximize the customization of care available to members. While most benefit plans prescribe coverage only for specified types of care, this program enables Magellan's care management team to approve treatment at the level of care that best meets the member's need, within the customer organization's contractual allowance for ECB and the member's consent.

*Policies: Extra Contractual Benefits Eligibility and Management*

### Section IV: Clinical Review Support Tools

#### **Medical Necessity Criteria**

The *Magellan Behavioral Health Medical Necessity Criteria* is a set of explicit clinical review criteria and application approaches for recognized settings of behavioral health treatment used to determine the medical necessity and clinical appropriateness of requested services.

On an annual basis, a Medical Necessity Criteria Task Force, a multi-disciplinary group of practitioners with clinical knowledge and expertise in behavioral healthcare led by the SVP Medical Services, is formed to conduct the annual review and updating, as applicable, of the *Magellan Behavioral Health Medical Necessity Criteria*.

Mechanisms implemented by the Medical Necessity Criteria Task Force to conduct the review and make recommendations for updating the criteria include:

- ⇒ Soliciting input from providers at the local level via participation on CMC provider advisory groups or other committees; meetings with customer Medical Directors; individual comments or through provider surveys.
- ⇒ Obtaining input from providers at a national level via the National Provider Advisory Board whose membership includes locally or nationally recognized practitioner experts in the fields of substance abuse and mental health and who represent the perspectives of academic institutions and professional associations.
- ⇒ Assessing the criteria remain objective and based on clinical evidence by conducting a search of the literature on the latest outcome studies and scientific research in the field of psychiatry and substance abuse published since the previous annual review.
- ⇒ Evaluating trends related to the consistency with which clinical care management staff apply medical necessity criteria.
- ⇒ Examining recommendations for consistency against current Magellan policies and clinical practice guidelines.

Final recommendations for the updated version of the criteria are presented to the National Professional Provider Review Committee and Corporate UM Committee for approval.

Copies of the *Magellan Behavioral Health Medical Necessity Criteria* are available to all providers via Magellan's web site and the *Magellan Behavioral Health Provider Handbook* is provided to new providers upon entering the network and are further available to providers upon request. Alerts about revisions or updates to the *Magellan Behavioral Health Medical Necessity Criteria* are distributed to existing network providers via the provider newsletter and/or bulletins.

In certain instances, such as member population needs, customer requirements, or state law mandate, care management decisions use modified *Magellan Behavioral Health Medical Necessity Criteria* or other alternative specific clinical review or medical necessity criteria sets. In these instances, at the time of contracting, the Chief Medical Officer or designee reviews these alternate criteria to assess whether they are consistent with good clinical practice.

(The Iowa CMC are contractually required by the State to use "psychosocial necessity" criteria for mental health services and "service necessity" criteria as embodied in the ASAM PPC-2R for substance abuse services.)

<i>Policies: Medical Necessity Criteria Development and Revision</i>
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#### **Clinical Practice Guidelines**

Clinical practice guidelines are clinical decision support tools that guide providers, members, and Magellan's clinical care management staff in determining the clinical appropriateness of services in specific clinical circumstances for the treatment of acute and chronic behavioral health conditions.

### Section IV: Clinical Review Support Tools

The Chief Medical Office appoints practitioners with clinical knowledge and expertise in behavioral healthcare to a Clinical Practice Guideline Task Force which is responsible to recommend approval to develop and/or adopt evidence based clinical practice guidelines from recognized sources.

The task force also is responsible for the review and updating, as applicable, of adopted clinical practice guidelines at least every two years or earlier as determined by the task force based on published scientific evidence-based advancements in the field of psychiatry and substance abuse.

The Clinical Practice Guideline Task Force carries out the following activities in order to fulfill its responsibilities:

- ⇒ Soliciting input from providers at the local level via participation on CMC provider advisory groups or other committees; meetings with customer Medical Directors; individual comments or through provider surveys.
- ⇒ Obtaining input from providers at a national level via the National Provider Advisory Board whose membership includes board certified behavioral health practitioners.
- ⇒ Gathering input from relevant community agencies and members as appropriate.
- ⇒ Assessing available clinical practice guidelines from recognized sources such as the American Psychiatric Association (APA) and recent clinical practice literature on the latest outcome studies and scientific research in the field of psychiatry and substance abuse.
- ⇒ Evaluating results of clinical process of care measurements relevant to the clinical practice guideline under review.
- ⇒ Examining recommended clinical practice guideline for consistency against current Magellan policies, criteria and member educational information.

Final recommendation of the clinical practice guideline for adoption or updating are presented to the Corporate UM Committee for input and the National Professional Provider Review Committee for approval.

Magellan makes its guidelines available to network providers and clinical care management staff. In addition, Magellan furnishes members with consumer-relevant information based on the adopted practice guideline, as allowed by contract.

<i>Policies: Clinical Practice Guidelines</i>
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#### ***Behavioral Healthcare Related Technology Assessment***

Magellan's new technology assessment process provides its customer organizations with findings and recommendations for inclusion of new technologies or new applications of existing medical technologies, procedures, pharmaceuticals or devices relevant to behavioral healthcare.

The process may be initiated as a result of a newly published scientific evidence-based advancement in the field of behavioral healthcare or a provider request. The Chief Medical Officer designates a New Technology Task Force of appropriate behavioral healthcare clinicians and practitioners and may include representatives of customer organizations and primary care practitioners, as appropriate to conduct the new technology assessment. The assessment process includes review of information from appropriate government regulatory agencies, published scientific literature, soliciting input from relevant specialists and professionals with expertise in the technology under review and materials submitted by the requestor and other proponents. The new technology is then assessed against Magellan's New Technology Assessment criteria.

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### Section IV: Clinical Review Support Tools

Findings and recommendations from the new technology assessment process are presented to the Corporate UM Committee and the National Professional Provider Review Committee for review and input as to consistency with current clinical practice guidelines, care management processes and criteria as well as national provider and member materials.

The final recommendations of the new technology assessment is forwarded to CMCs for review by their Quality Improvement Committee for consistency with policies, member and provider materials, as well as local customer organization benefits. Distribution of the final new technology assessment recommendations to customers for consideration of inclusion in their benefits are forwarded by the appropriate Magellan corporate or CMC level relevant to the scope of the customer's contractual relationship.

The technology assessment review criteria and process are reviewed by the Corporate UM Committee at least annually.

<i>Policies: New Technology Assessment</i>
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### Section V: Integration with QI

The QI Program includes a Work Plan which contains indicators and monitoring activities based on specifications, standards and goals recommended by the Corporate UM Committee for measurement of care management activities and processes.

#### **Core Performance Indicators**

Magellan has developed a core set of performance measures, called Core Performance Indicators (CPIs) which are collected by staff at the CMC level. CPI results are aggregated at established frequencies but no less than annually by each CMC and reported to the corporate QI Outcomes & Research department for distribution to corporate committees. The Corporate UM Committee reviews results of CPIs relevant to care management activities and makes recommendations to support CMC improvements as applicable.

CPI data are used at both the corporate and CMC level in evaluating the effectiveness of care management activities and processes as well as achievement of established program goals.

The *Core Performance Indicators* that have oversight by the Corporate UM Committee are:

- Accessibility of Behavioral Healthcare Services
- Acute inpatient readmission
- Ambulatory follow-up after discharge from acute inpatient stay
- Timeliness and outcome measures for initial claim review and appeal process
- Provider and member satisfaction survey responses related to the UM program

#### **Performance Monitoring Activities**

In addition to the CPIs, each CMC conducts performance monitoring activities per the requirements indicated in their QI Work Plan. The Corporate UM Committee reviews results of performance monitoring relevant to care management activities and makes recommendations to support CMC improvements as applicable. The relevant performance monitoring is as follows:

##### Behavioral Healthcare Resource Utilization Evaluation

This annual activity supports Magellan's care management philosophy. Optimum behavioral healthcare resource utilization is ascertained via the systematic analysis of pertinent quantitative and qualitative measures against relevant and established thresholds to identify performance gaps or outliers (under and over utilization) and effect on treatment outcome. The CMC is expected to establish quantitative utilization thresholds using external and/or regional utilization statistics as well as CMC member population, regional, provider network, account and CMC characteristics.

##### Clinical Practice Guideline Aspect Measurement

At least annually, the CMC analyzes collected data to evaluate at least two (2) measures of care processes (sometimes referred to as aspect of care) relevant to one or both of the adopted clinical practice guidelines. This activity was formerly referred to as adherence to clinical practice guidelines.

##### Coordination of Care

This activity includes the completion and implementation of a CMC-specific Medical Integration Plan; evaluation of timely and confidential exchange of applicable behavioral healthcare evaluation and treatment with primary care practitioners; and collaboration with medical practitioners to increase appropriate use of psychotropic drugs.

##### Intensive Care Management Program

CMCs review ICM indicator results and achievement of ICM goals to evaluate effectiveness.

### Section V: Integration with QI

#### Medical Necessity Criteria Inter-rater Reliability

This annual activity evaluates the consistency with which clinical care management staff (CMs and PAs) apply medical necessity criteria. Methods of collecting data for this activity may include peer and/or supervisor audits of case files, audit of clinical documentation related to determinations of the clinical review and appeal process by the CMC Medical Director.

#### Member Safety

CMCs address member safety issues and recommend improvements as needed. Some examples of activities that a CMC can demonstrate promoting member safety are:

- ⇒ Recognizing potential member safety issues through analysis of complaints, adverse incidents and coordination of care data.
- ⇒ Improving member knowledge about their condition and treatment through member relevant clinical practice guideline information, compliance with aftercare reminders and outreach.
- ⇒ Enhancing provider awareness of better practices through sharing provider level process and outcome data, distributing clinical practice guideline information and identify clinical practice barriers that may be related to care management processes.

#### Prevention Programs

CMCs provide prevention programs' indicator results and achievement of prevention program goals to evaluate program effectiveness.

#### Timeliness and Documentation of Clinical Review and Appeal Process

Case files are audited against established timeliness and documentation indicators based on Magellan standards and CMC-specific standards based on customer or state requirements.

<i>Policies:</i>	<i>Evaluation of Behavioral Health Service Utilization Medical Integration Plan Preventive Behavioral Healthcare</i>
<i>Other:</i>	<i>Quality Improvement Program Description QI Work Plan</i>

#### **Annual Evaluation of UM Program**

The Corporate UM Committee has authority over the *Magellan Behavioral Health UM Program Description* which is reviewed and evaluated on an annual basis for overall program effectiveness to:

- critically evaluate the degree to which the goals and objectives of the UM Program are met;
- identify opportunities to improve the quality of care management processes, including UM functions across the organization;
- identify areas for improvement in clinical operational efficiency; and
- identify "better practices" to be implemented across the organization.

The formal evaluation is documented within the annual QI Program Evaluation and includes findings and results obtained through QI Work Plan Core Performance Indicators and Performance Monitoring activities as well as internal audits conducted by the Compliance Department and external audits conducted by customers, accreditors and regulatory agencies.

Review of the annual evaluation as well as approval of the UM Program description is reflected in the appropriate committee minutes.

**Appendix F**

**Cultural Competence Plan**

**Magellan Health Services /**

**Magellan Behavioral Care of Iowa**

**July 2008 - June 2009**

**Quality Improvement Program Description  
for the  
Iowa Plan for Behavioral Health**

## Iowa CMC Cultural Competence Action Plan

<b>Objectives</b>	<b>Steps to Achieve the Objective</b>	<b>Person/s Responsible</b>	<b>Time frame</b>
<b>Draft Mission Statement</b>	<b>Review CC materials &amp; definition to create mission statement</b>	<b>Group</b>	<b>Completed</b>
<b>Create CC Plan</b>	<ul style="list-style-type: none"> <li>- <b>Mission Statement</b></li> <li>- <b>Guiding Principles</b></li> <li>- <b>Definitions</b></li> <li>- <b>Goal/Objectives</b></li> </ul>	<b>Learning Lead</b>  <b>QI / Compliance Director</b>	<b>Completed</b>
<b>Develop Promotional Material</b>	<ul style="list-style-type: none"> <li>- <b>Sharing mission statement, goals, definition, guiding principles</b></li> <li>- <b>Explore promotional materials (pencils, posters etc.)</b></li> </ul>	<b>Consumer/Family Advocate</b>	<b>Ongoing</b>
<b>Communication Strategy</b>	<b>- Create PR document to share group's progress</b>	<b>Learning Lead</b>  <b>QI / Compliance Director</b>	<b>TBD</b>

<b>Objectives</b>	<b>Steps to Achieve the Objective</b>	<b>Person/s Responsible</b>	<b>Time frame</b>
<b>Staff assessment to determine educational needs</b>	<ol style="list-style-type: none"> <li>1. Define purpose of assessment tool.</li> <li>2. Determine appropriate assessment tool (pre &amp; post)</li> <li>3. Contact Melana for assessment tools</li> <li>4. Who speaks what languages</li> <li>5. Determine what languages are calling-in</li> <li>6. Administer tool</li> <li>7. Review results</li> </ol>	<b>Consumer/Family Advocate</b>	<b>6 months</b>
<b>Basic Spanish Language In-service</b>	<ol style="list-style-type: none"> <li>1. Develop an internal training on basic Spanish to be used by CSA/CMS</li> <li>2. Teach staff how to use Pac.Interpreters</li> </ol>	<b>Learning Lead Care Manager</b>	<b>Completed</b>
<b>Resources</b>	<b>Create Resource materials for internal staff</b> <ul style="list-style-type: none"> <li>- Cheat sheet for staff for languages</li> <li>- Provider Search Training</li> <li>- Corporate Resources</li> </ul>	<b>Network</b>	
<b>Internal Training</b>	<b>2-3 CC trngs/yr - at least 1 to originate in Lincoln</b>	<b>Learning Lead</b>	<b>12 mos</b>

<b>Objectives</b>	<b>Steps to Achieve the Objective</b>	<b>Person/s Responsible</b>	<b>Time frame</b>
<b>Resources</b>	<b>Develop resource material for providers (members)</b>	<b>Network</b>	<b>12 months</b>
<b>Share CC plan &amp; data w/providers</b>	<b>~ Share in Provider Roundtables, Clinical Advisory, Consumer/Family Roundtables, IPR, etc.</b>	<b>QI/Compliance Director</b>	<b>12 months</b>
<b>Provider CC Pilot Project</b>	<b>~ Explore Pilot Project w/providers</b>	<b>QI / Compliance Director</b>	<b>24 mos</b>
<b>Promoting CC Materials on Website</b>	<b>~ Training Providers ~ Newsletters ~ Reminders to Providers</b>	<b>TBD</b>	
<b>Provider CC Training</b>	<b>~ Provide at least one provider training on CC ~ Educate about free CEU online</b>	<b>Learning Lead</b>	<b>12 mos</b>

<b>Objectives</b>	<b>Steps to Achieve the Objective</b>	<b>Person/s Responsible</b>	<b>Time frame</b>
<b>Care Manager process</b>	~ Develop questions for CM/CSA to ask during reviews	<b>Clinical</b>	<b>12 months</b>
<b>Recognition of Staff for using CC tools</b>	~ SERP/Observations tools	<b>Learning Lead</b>	
<b>QI Review for Provider CC in clinical</b>	~Add to QI Review Tools ~ Technical Assistance	<b>QI/Compliance Director</b>	<b>Completed</b>
<b>Pre/Post Test Magellan Staff CC Awareness</b>	~ Administer and Review Survey results	<b>Learning Lead</b> <b>Consumer/Family Advocate</b>	<b>12 mos</b>

<b>Objectives</b>	<b>Steps to Achieve the Objective</b>	<b>Person/s Responsible</b>	<b>Time frame</b>
<b>Obtain data about staff</b>	<ul style="list-style-type: none"> <li>~ Who speaks what languages</li> <li>~ Self-reported expertise &amp; ability to share w/others</li> <li>~ Providers who specialize</li> </ul>	<b>Operations</b>	<b>12 mos</b>
<b>Obtain data about providers</b>	<ul style="list-style-type: none"> <li>~ Languages</li> <li>~ Ethnicity</li> <li>~ Religion</li> <li>~ Special Populations</li> <li>~ Provider Survey Question</li> </ul>	<b>QI / Compliance Director</b>	<b>Completed</b>
<b>Obtain data about members</b>	<ul style="list-style-type: none"> <li>~ Collecting info about members and utilization patterns</li> <li>~ Geographic areas</li> <li>~ Satisfaction Survey questions</li> </ul>	<b>QI/Compliance Director</b>  <b>QI Specialists</b>	<b>12 mos</b>
<b>Develop Performance Activity using data measures</b>	~ Cultural Differences in Utilization (IA)	<b>QIC</b>	<b>24 mos</b>

**Appendix G**

**Innovation Plan**

**Magellan Health Services /**

**Magellan Behavioral Care of Iowa**

**July 2008 - June 2009**

**Quality Improvement Program Description  
for the  
Iowa Plan for Behavioral Health**

## 2008 Innovations Plan: Iowa Care Management Center

### Goal # 1: Promote choice, direction, and control by people in recovery and families.

Next steps needed to achieve objective	Person/s Responsible	Due date	Completion Date	Notes	Key metrics for measuring progress	Report on key metrics (fill in as plan is updated)	Resources Needed
<b>A: Promote meaningful contributions by consumers and families on workgroups and advisory committees</b>							
1. Develop baseline measures of meaningful contributions by consumers and families and assess any gaps - such as geographic representation, other key constituencies.	C.Sims / D. Johnson (and R/R Workgroup)	7/1/2008 -- propose to change to 8/31		Working on this...not complete yet -- need to revise due date as other priorities have come up -- flooding, community reinvestment, etc.	1. # vacant positions for consumers		Background: QIC committee and consumer/family advisory as areas of focus
2. Recruit 1 to 3 additional stakeholders to serve on QI committees, can use low cost/ high impact strategies for outreach and recruitment efforts	C.Sims / D. Johnson	7/1/2008	6/6/2008	Added 2 providers to QIC and at least 3 consumer/family members to Consumer/Family Advisory Committee	2. # vacant positions for family members		Background: A dynamic group, lots of sharing ideas, sharing agenda items, focus on community reinvestment projects, performance indicator review, quarterly report review, etc.
3. To boost effectiveness/contributions from existing members, create a survey for existing members on their level of involvement, support needed, etc.	C.Sims / D. Johnson (and R/R Workgroup)	8/31/2008		Developing	3. # new community stakeholders recruited over last 3 months		
4. Implement survey with existing members	C.Sims / D. Johnson (and R/R Workgroup)	9/30/2008		developing survey	4. % of meeting minutes demonstrating evidence of consumer and family impact		Tom Lane and Pat Hunt have a resource for surveying committee members about their level and scope of participation.
5. Share results of survey with existing members and spark dialogue around next steps to take committee participation to the next level	C.Sims / D. Johnson	10/31/2008		developing survey	5. Summary of results from survey process with existing committee members		
6. Develop orientation for new members to the committee, their role, common acronyms, etc.	C.Sims / D. Johnson (and R/R Workgroup)	11/30/2008	6/5/2008	Consumer/Family Advisory orientation complete with new members (and existing)			Tom Lane and Pat Hunt have developed a resource for orientation for new committee members.
7. Implement orientation for new members	C.Sims / D. Johnson	12/1/2008	6/5/2008	Consumer/Family Advisory orientation complete with new members (and existing)			

**B. Promote consumer and family choice, direction, and control in treatment planning**

1. Adapt treatment record review tool to incorporate evidence of consumer and family choice, direction, and control through strategies such as psychiatric advance directives, WRAP, addressing cultural competency etc. Start with TRR from Lehigh and make adjustments as needed	C. Sims	5/1/2008	5/15/2008	Complete	1. # treatment records reviewed		
2. Implement enhanced treatment record review tool	C. Sims	6/1/2008	6/1/2008	Complete	2. # of network providers for whom treatment records are reviewed		
3. Present new tool at quarterly provider roundtable over ICM	C. Sims	7/31/2008	7/17/2008	To be done 7/17-- done today	3. Summary of scores from treatment record review		Training is being developed around this – Provider Roundtable scheduled for June 2008
4. Compile summary of results from using new tool and next steps needed	C. Sims	12/31/2008		Nothing to do with this yet			

**Goal # 2: Service center transformation around principles of resiliency, cultural competency, and recovery**

Next steps needed to achieve objective	Person/s Responsible	Due date	Completion Date	Notes	Key metrics for measuring progress	Report on key metrics (fill in as plan is updated)	Resources Needed
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**A. Implement Consumer Health Inventory in recovery/resiliency care management program**

1. Identify process flow needed for implementing Consumer Health Inventory	S. Johnson	Complete	Spring 08		1. % of completed CHIs at intake for members in r/r care management during last three months		
2. Implement Consumer Health Inventory	S. Johnson	Complete	Spring 08		2. % of completed CHIs at discharge		
3. Report on results	S. Johnson	Quarterly		nothing to report yet	3. Aggregate scores from CHIs		
4. Act on the results: talk with staff about what the outcomes mean, what to do with individual as well as aggregate reports going forward	S. Johnson	Ongoing					

**B: Integrate and implement core components of cultural competency, resiliency and recovery in our service observation tools for all employees**

1. Work with Tom Lane and national workgroup to revise and enhance service observation tools for customer service associates to reflect core components of cultural competency, resiliency, and recovery	S. Johnson/ D. Johnson	8/31/2008			1. Establish enhanced service observation tool for customer service associates		Background: Tom Lane will facilitate a national workgroup on this
2. Implement enhanced service observation tools for customer service associates	S. Johnson	9/1/2008			2. Summary of results from pilot and recommendations for moving forward		
3. Develop summary of results based on pilot and recommendations for going forward	S. Johnson	11/30/2008					

**C: CMC staff to attend in-person and on-line training modules on resiliency and recovery**

1. In-person trainings scheduled	J. Barker	Complete		got note on online trainings today -- will discuss how to approach and set goals for completion	1. % of employees attending in-person training		Background: CMC and Provider training conducted 12/5 and 12/6? 1/22 and 1/23 with Jim Stringham and Pat Hunt
2. In-person training conducted	J. Barker	Complete			2. % of employees completing on-line modules		
3. On-line modules are publicized to CMC staff	J. Barker	3/1/2008		Potential barriers – other required courses for employees, look at spreading these out across year so that employees are not bombarded			Ensure trainings are available on LearnIt
4. On-line modules are completed by CMC staff	J. Barker	12/31/2008		How long do these 10 modules take? How many are reasonable to expect people to take? -- got note today about completing 5 of these -- will still be challenging			

**D: Promote cultural competence across our CMC and in service delivery network**

1. Cultural competence plan drafted	J. Barker	Complete			1. CMC cultural competence plan completed		Background: Iowa's Cultural Competence Plan is a separate plan.
2. Cultural competence plan reviewed for feedback by National Director, Cultural Competence	J. Barker	Complete			2. Evidence of successful implementation of plan components		
3. Key components of cultural competence plan are implemented : basic Spanish language instruction; 2 - 3 staff trainings/year; performance improvement project on cultural differences in utilization	J. Barker / C. Sims	12/31/2008	Working on all of this -- in process		3. Number of trainings, in-service sessions and number of staff attendees		

**E: Promote recovery/resiliency across our CMC and in service delivery network**

1. Recovery/resiliency CMC workgroup formed	D. Johnson	3/1/2008	4/1/2008		1. Recovery/Resiliency plan completed		Background:R-R Workgroup formed with members from every area of CMC, including after-hours staff, reporting analyst
2. Monthly activities highlighting Magellan's core r-r principles conducted in Jan - March	D. Johnson	4/30/2008	3/31/2008	Diane highlights R/R principles at every monthly all-staff meeting -- often an activity is attached to these	2. Measure attendance/participation at various activities		Background: R-R workgroup held a contest showing bits and piece of a picture, to figure out the whole picture going on...(this for the principle of holistic)
3. Monthly activities highlighting Magellan's core r-r principles conducted in April - June	D. Johnson	7/31/2008		Diane highlights R/R principles at every monthly all-staff meeting -- often an activity is attached to these	3. Metrics to monitor progress of implementing this Innovations plan		
4. Monthly activities highlighting Magellan's core r-r principles conducted in July - Sep	D. Johnson	10/31/2008		Diane highlights R/R principles at every monthly all-staff meeting -- often an activity is attached to these			
5. Monthly activities highlighting Magellan's core r-r principles conducted in Oct - Dec	D. Johnson	1/31/2009		Diane highlights R/R principles at every monthly all-staff meeting -- often an activity is attached to these			
6. R-R CMC workgroup will monitor successful implementation of this Innovations plan	D. Johnson	Ongoing					

**Goal # 3: Innovative service delivery and program approaches through partnerships with our provider network and other stakeholders**

Next steps needed to achieve objective	Person/s Responsible	Due date	Completion Date	Notes	Key metrics for measuring progress	Report on key metrics (fill in as plan is updated)	Resources Needed
<b>A. Peer Support</b>							
1. Convene roundtable on peer support	S. Johnson / K. Hauser	Complete	1/31/2008		1. Development of fidelity tools and competency tools		Background: This is also a Performance Improvement Project.
2. Develop fidelity tools and competency tools	C. Sims -- Roundtable members	6/30/2008 -- suggest revision to be 9/30/08		In development -- provider-driven -- still working on these in Provider Roundtable -- suggest new target completion date	2. Summary of scores from competency tool		Background: Had several providers proposing peer support projects so they started a roundtable with all providers of peer support.
3. Implement tools with all peer support providers	C. Sims -- Roundtable members	7/1/2008 -- suggest revision to be 12/31		Tools being developed -- again suggest revising target date -- roundtable is doing EXCELLENT work, but has been focusing on the guidelines prior to developing the tools	3. # of roundtable meetings and attendance at roundtable meetings		Background: The goal is to together collectively support peer support activities by sharing ideas to help each other. Discussion topics include hiring practices, what trainings do they need, how soon do they need certification after they are hired, questions /guidelines about supervision, etc.
4. Summary of results from implementation of fidelity and competency tools	C. Sims -- Roundtable members	12/31/2008		Tools being developed			Background: Peer support staff also participate in the roundtable meetings

**B. Behavioral Health/Medical Care Coordination**

1. Commence project with Iowa Medicaid Enterprise Institute	C. Sims	Complete	late 2006		1. Compile results from PHQ-9 depression screenings		Background: This is a Performance Improvement Project
2. Analyze cost of care dollars, before and after, for people who receive the PHQ-9 screening	(C. Wadle, S. Johnson, S. Ottoson)	10/31/2008		Assessing how to best pull and analyze data -- working with Melissa Havig	2. Results of pre and post cost of care dollars and other measures (PHQ-9 and CHI)		Background: Magellan collaborates with the Iowa Medicaid Enterprise Institute ? on this.
							Background: Hoping to use the CHI as well as the PHQ-9

**C. Community Reinvestment**

1. New Community Reinvestment RFP issued	C. Sims	Complete	Apr-08		1. Number of new projects selected for funding through Integrated Recovery and Access Community Reinvestment		Background: stakeholder meetings on Community Reinvestment RFP already in progress
2. Select projects through review/evaluation committee	C. Sims	6/17/2008	14-Jul	Eval committee identified and in process of review -- meeting on 6/17	2. Outcomes measures to be identified -- including number of Iowa Plan enrollees included in each project		
3. Measure outcomes of these projects	C. Sims	Quarterly after 8/1/08			3. Number of fact sheets and opportunities for "marketing"		
4. Write fact sheets on each type of project through current and new community reinvestment	C. Sims	Ongoing		In process on older projects			

## 2008 Innovations Plan: Iowa Care Management Center

### Goal # 2: Service center transformation around principles of resiliency, cultural competency, and recovery

Next steps needed to achieve objective	Person/s Responsible	Due date	Completion Date	Notes	Key metrics for measuring progress	Report on key metrics (fill in as plan is updated)	Resources Needed
<b>A. Implement Consumer Health Inventory in recovery/resiliency care management program</b>							
1. Identify process flow needed for implementing Consumer Health Inventory	S. Johnson	Complete	Spring 08		1. % of completed CHIs at intake for members in r/r care management during last three months		
2. Implement Consumer Health Inventory	S. Johnson	Complete	Spring 08		2. % of completed CHIs at discharge		
3. Report on results	S. Johnson	Quarterly		nothing to report yet	3. Aggregate scores from CHIs		
4. Act on the results: talk with staff about what the outcomes mean, what to do with individual as well as aggregate reports going forward	S. Johnson	Ongoing					
<b>B: Integrate and implement core components of cultural competency, resiliency and recovery in our service observation tools for all employees</b>							
3. Develop summary of results based on pilot and recommendations for going forward	S. Johnson	11/30/2008					
<b>C: CMC staff to attend in-person and on-line training modules on resiliency and recovery</b>							
1. In-person trainings scheduled	J. Barker	Complete		got note on online trainings today -- will discuss how to approach and set goals for completion	1. % of employees attending in-person training		Background: CMC and Provider training conducted 12/5 and 12/6? 1/22 and 1/23 with Jim Stringham and Pat Hunt
2. In-person training conducted	J. Barker	Complete			2. % of employees completing on-line modules		
3. On-line modules are publicized to CMC staff	J. Barker	3/1/2008		Potential barriers – other required courses for employees, look at spreading these out across year so that employees are not bombarded			Ensure trainings are available on LearnIt
4. On-line modules are completed by CMC staff	J. Barker	12/31/2008		How long do these 10 modules take? How many are reasonable to expect people to take? -- got note today about completing 5 of these -- will still be challenging			

**D: Promote cultural competence across our CMC and in service delivery network**

1. Cultural competence plan drafted	J. Barker	Complete			1. CMC cultural competence plan completed		Background: Iowa's Cultural Competence Plan is a separate plan.
2. Cultural competence plan reviewed for feedback by National Director, Cultural Competence	J. Barker	Complete			2. Evidence of successful implementation of plan components		
3. Key components of cultural competence plan are implemented : basic Spanish language instruction; 2 - 3 staff trainings/year; performance improvement project on cultural differences in utilization	J. Barker / C. Sims	12/31/2008	Working on all of this -- in process		3. Number of trainings, in-service sessions and number of staff attendees		
4. Act on the results: talk with staff about what the outcomes mean, what to do with individual as well as aggregate reports going forward							

3. Monthly activities highlighting Magellan's core r-r principles conducted in April - June	D. Johnson	7/31/2008		Diane highlights R/R principles at every monthly all-staff meeting -- often an activity is attached to these	3. Metrics to monitor progress of implementing this Innovations plan		
4. Monthly activities highlighting Magellan's core r-r principles conducted in July - Sep	D. Johnson	10/31/2008		Diane highlights R/R principles at every monthly all-staff meeting -- often an activity is attached to these			
5. Monthly activities highlighting Magellan's core r-r principles conducted in Oct - Dec	D. Johnson	1/31/2009		Diane highlights R/R principles at every monthly all-staff meeting -- often an activity is attached to these			
6. R-R CMC workgroup will monitor successful implementation of this Innovations plan	D. Johnson	Ongoing					

## 2008 Innovations Plan: Iowa Care Management Center

### Goal # 3: Innovative service delivery and program approaches through partnerships with our provider network and other stakeholders

Next steps needed to achieve objective	Person/s Responsible	Due date	Completion Date	Notes	Key metrics for measuring progress	Report on key metrics (fill in as plan is updated)	Resources Needed
<b>A. Peer Support</b>							
1. Convene roundtable on peer support	S. Johnson / K. Hauser	Complete	1/31/2008		1. Development of fidelity tools and competency tools		Background: This is also a Performance Improvement Project.
2. Develop fidelity tools and competency tools	C. Sims -- Roundtable members	6/30/2008 -- suggest revision to be 9/30/08		In development -- provider-driven -- still working on these in Provider Roundtable -- suggest new target completion date	2. Summary of scores from competency tool		Background: Had several providers proposing peer support projects so they started a roundtable with all providers of peer support.
3. Implement tools with all peer support providers	C. Sims -- Roundtable members	7/1/2008 -- suggest revision to be 12/31		Tools being developed -- again, suggest revising target date -- roundtable is doing EXCELLENT work, but has been focusing on the guidelines prior to developing the tools	3. # of roundtable meetings and attendance at roundtable meetings		Background: The goal is to together collectively support peer support activities by sharing ideas to help each other. Discussion topics include hiring practices, what trainings do they need, how soon do they need certification after they are hired, questions /guidelines about supervision, etc.
4. Summary of results from implementation of fidelity and competency tools	C. Sims -- Roundtable members	12/31/2008		Tools being developed			Background: Peer support staff also participate in the roundtable meetings
1. Commence project with Iowa Medicaid Enterprise Institute	C. Sims	Complete	late 2006		1. Compile results from PHQ-9 depression screenings		Background: This is a Performance Improvement Project
2. Analyze cost of care dollars, before and after, for people who receive the PHQ-9 screening	(C. Wadle, S. Johnson, S. Ottoson)	10/31/2008		Assessing how to best pull and analyze data -- working with Melissa Havig	2. Results of pre and post cost of care dollars and other measures (PHQ-9 and CHI)		Background: Magellan collaborates with the Iowa Medicaid Enterprise Institute ? on this.
<b>C. Community Reinvestment</b>							
1. New Community Reinvestment RFP issued	C. Sims	Complete	Apr-08		1. Number of new projects selected for funding through Integrated Recovery and Access Community Reinvestment		Background: stakeholder meetings on Community Reinvestment RFP already in progress
2. Select projects through review/evaluation committee	C. Sims	6/17/2008	14-Jul	Eval committee identified and in process of review -- meeting on 6/17	2. Outcomes measures to be identified -- including number of Iowa Plan enrollees included in each project		
3. Measure outcomes of these projects	C. Sims	Quarterly after 8/1/08			3. Number of fact sheets and opportunities for "marketing"		
4. Write fact sheets on each type of project through current and new community reinvestment	C. Sims	Ongoing		In process on older projects			

**AGENDA**  
**Conference Call #: 866/292-9469, 114714#**

1. **OLD BUSINESS** **Chris Sims**
  - a. Review and Approval of Past Minutes *monthly*
  
2. **EXTERNAL AUDITS / REGULATORY COMPLIANCE** **Chris Sims**
  - a. Policies *quarterly Feb, May, Aug, Nov08*
  - b. Regulatory Compliance *quarterly Jan, Apr, July, Oct08*
    - Compliance Committee
  - c. Fraud and Abuse *monthly*
  - d. Other Specific Activities
    - External Quality Review *Jan, Feb, and results in Apr or May08*
    - URAC *every three years*
  
3. **KEY INDICATOR REPORTS**
  - a. QI Workplan *monthly* **Dennis Petersen**
  - b. Documentation Reviews *quarterly Feb, May, Aug, Nov. 08* **Dennis Petersen**
    - Care Manager Audits
    - CSA Data Integrity Reviews
  - c. QI Quarterly Report *quarterly Mar, June, Sept, Dec08* **Chris Sims**  
*Note highlights; identify improvement opportunities/trends to follow and follow-up plan. Report follow-up plan as steps are completed.*
  - d. QI Annual Report/Evaluation *bi-annual May, Sept 08* **Chris Sims**
  - e. QI Program Description/Work Plan *bi-annual Apr, Oct 08* **Chris Sims**
  - f. Annual QI Goals *annually July'08* **Chris Sims**
  
4. **QUALITY IMPROVEMENT ACTIVITIES**
  - a. Performance Measures *monthly* **Chris Sims**
    - Schizophrenia 7-day Follow Up
  - b. Client Satisfaction Surveys *quarterly Feb, May, Aug, Nov08* **Chris Sims**
  - c. Critical Incidents *quarterly Mar, June, Sept, Dec08* **Nickie Meyerring**
  - d. Provider Incidents *quarterly Jan, Apr, July, Oct. 08* **Nickie Meyerring**
  - e. Performance Improvement Projects *monthly,* **Chris Sims**
    - Cultural Differences in Utilization (2005) *Mar, June, Sept, Dec08*
    - Reward for Quality (2006) *Feb, May, Aug, Nov08*
    - Behavioral and Medical Care Coordination (2007) *Jan, Apr, July, Oct 08*
    - Peer Support Services (2007) *Feb, May, Aug, Nov 08*
  - f. Physician Advisor Peer Review *quarterly Jan, Apr, July, Oct08* **Dr. Wadle**
  - g. Prevention Projects *monthly (if also a PIP, use that schedule)*
    - ADHD/Depression (2004) *Aug, Nov, Feb, May09* **Diane Johnson**
    - Postpartum Depression (2005) *Jan, Apr, July, Oct08* **Kim Hauser**
    - Reward for Quality (2006) *Feb, May, Aug, Nov08* **Chris Sims**
    - Behavioral and Medical Care Coordination (2007) *Jan, Apr, July, Oct08* **Chris Sims**
  - h. Provider Satisfaction Survey *bi-annual Jan, June08* **Chris Sims**

Iowa Plan for Behavioral Health  
Quality Improvement Committee: DATE, TIME

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*Note highlights and review by Clinical Advisory Committee, Member Services, and PPRC. Identify follow up plan and report on follow up plan as steps are completed.*

- i. Treatment Record Review Tool *May 08* **Chris Sims**
  
- 5. **APPEALS / GRIEVANCES / COMPLIMENTS** *quarterly* **Joyce Claman**
  - a. Appeals *Feb, May, Aug, Nov08*
  - b. Compliments *Jan, Apr, July, Oct08*
  - c. Grievances *Mar, June, Sept, Dec08*
  
- 6. **SUBCOMMITTEE REPORTS** *quarterly*
  - a. Advisory Committees
    - Iowa Plan Advisory Committee *Feb, May, Aug, Nov08* **JDischer/CSims**
    - Clinical Advisory Committee *Mar, June, Sept, Dec08* **JDischer/Dr.Wadle**
    - Consumer/Family Advisory Committee *Aug, Nov, Feb, May09* **Diane Johnson**
  - b. CEU/Professional Development Subcommittee *Jan, Apr, July, Oct08*
    - All-Staff Meeting **Julie Carlson**
    - Clinical Staff Meeting
    - Cultural Competency
  - c. Member Services Subcommittee *Aug, Nov, Feb, May09* **Diane Johnson**
    - Common Areas Confidentiality Audit *Aug '08*
    - Member Communications Annual Review *Aug '08*
  - d. Professional Provider Review Subcommittee *Feb, May, Aug, Nov08* **Dr. Wadle**
    - Patient Safety Survey Review *quarterly*
    - Clinical Practice Guideline Approval *May 08 then every Feb starting in 09.*
  - e. Utilization Management Subcommittee *Mar, June, Sept, Dec 09* **Kim Hauser**
    - Utilization Management Guidelines Review *Sept 08*
    - UM/ICM Program Description Approval *May '08 then every March. beginning March 09*
  
- 7. **OTHER**
  - a. Community Reinvestment *Jan, Apr, July, Oct08* **Chris Sims**
  - b. Provider Services Committee *Mar, June, Sept, Dec08* **Chris Sims**
    - Provider Profiling
    - Retrospective On-site Review
  
  - c. Roundtables *quarterly*
    - Children's Mental Health Stakeholders *May, Aug, Nov08* **Diane Johnson**
    - IPR Providers *Jan, Apr, Oct08* **Kim Hauser**
    - Provider Roundtable *Mar, June, Sept, Dec08* **Julie Carlson**
    - Women and Children Providers *Mar, June, Sept, Dec08* **L. HancockMuck**
    - Peer Support Providers *Feb, May, Aug, Dec08* **Kim Hauser**
    - Co-Occurring Disorders *Apr, July, Oct, Jan09* **L. Hancock-Muck**

d. Technical Assistance

**Magellan Staff**

**Next meeting: Date**

**MAGELLAN HEALTH SERVICES/MAGELLAN BEHAVIORAL CARE OF IOWA**

**IOWA CARE MANAGEMENT CENTER**

**JULY 2008 - JUNE 2009**

**QUALITY IMPROVEMENT WORKPLAN OVERVIEW**

for the

**IOWA PLAN FOR BEHAVIORAL HEALTH**



## **Magellan Behavioral Care of Iowa/Magellan Health Services Iowa Plan QI Work Plan Overview 2008 - 2009**

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### **Purpose/Scope**

The purpose of the Iowa Plan Quality Improvement (QI) Work Plan is to describe specific activities to be conducted during the 2008-2009 Iowa Plan contract year to promote continuous quality improvement and to support the Iowa QI Program. The QI Work Plan is an adjunct document to the 2008-2009 QI Program Description. The QI Work Plan incorporates issues identified through the 2007-2008 Annual Quality Assurance and Performance Improvement Report (annual QI evaluation); DHS and DPH feedback; recommendations from advisory, oversight and regulatory entities; and input from clients, consumers, members, family members, providers, staff, and other Iowa Plan stakeholders.

The QI Work Plan Overview includes goals and objectives for 2008-09. The attached QI Work Plan template includes specific Performance Indicators and potential quality improvement activity areas. The goal, data source, reporting interval, and responsible party are noted for each item. The attached QI Committee Agenda template indicates the minimum schedule for discussion of specific QI activities by the QI Committee.

### **Goals/Objectives**

The general goals and objectives of the Iowa QI Program for the 2008-2009 contract year, as approved by DHS, DPH, the Iowa Plan Advisory Committee, and the QI Committee are as follows.

#### **Broad Goals:**

1. Fulfill the requirements of the **Iowa Plan contract**.
2. Maintain a comprehensive and coordinated **Iowa Plan Quality Improvement (QI) program**.
3. Meet/exceed the standards of the **Iowa Plan Performance Indicators**.
4. Meet standards for **Magellan QI departments**.

#### **Specific Objectives:**

1. **Advisory Committees**  
Work with the three Iowa Plan advisory committees and with other stakeholder groups.
  - a. **Clinical Advisory Committee** advises Magellan on Iowa Plan clinical issues.
  - b. **Consumer/Family Advisory Committee** advises Magellan on Iowa Plan issues from the consumer and family perspectives.
  - c. **Iowa Plan Advisory Committee** advises DHS and DPH on Iowa Plan strategic and operational issues and provides for ongoing public input.
  - d. Hold **Provider Roundtables** over the ICN with continuing education presentations as well as Iowa Plan updates.

## Magellan Behavioral Care of Iowa/Magellan Health Services Iowa Plan QI Work Plan Overview 2008 - 2009

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- e. Host **Children's Mental Health Stakeholders Roundtables, IPR Roundtables, Women and Children's Coordinators Meetings, Co-Occurring Roundtables, and Peer Support Roundtables.**
  - f. Attend other stakeholder meetings as invited.
2. **Best Practices**
- a. **Support recovery and resiliency** in all activities by all staff, with leadership from the **Consumer/Family Advocate.**
  - b. **Support cultural competency** in all activities by all staff with the guidance of the Cultural Competency Workplan.
  - c. Continue to develop, support, and monitor Medicaid **Community Reinvestment** projects.
  - d. Promote dissemination of and compliance with Magellan **Clinical Practice Guidelines.**
  - e. Continue current PIPs, including **Peer Support** and **Behavioral Health and Medical Care Coordination.**
  - f. Initiate **Performance Measures**, as identified by the QI Committee, to understand trends and improvement opportunities.
  - g. Continue participation in DPH **Network for Improving Addiction Treatment (NIATx)** activities, including the **STAR-SI** project.
  - h. Participate in ongoing DPH and DHS initiatives relevant to **integration of services for co-occurring disorders.**
3. **Children's System of Care**
- a. Assure service coordination/integration for Medicaid-enrolled children in DHS's **Child Welfare** system, e.g. through Joint Treatment Planning.
  - b. Continue to support the Remedial Services system through provision of behavioral health assessments by Licensed Practitioners of the Healing Arts.
4. **External Reviews**
- a. Participate in DHS's annual **External Quality Review** of the Iowa Plan.
    - Conduct annual review of member materials, including the **Client Handbook** and **Provider Directory.**
    - Mail required **annual notification** newsletter to Medicaid enrollees.
  - b. Maintain **Utilization Review Accreditation Commission** accreditation.
  - c. Meet Iowa Insurance Division **Limited Service Organization** requirements.
  - d. Participate in other external reviews as scheduled, such as:
    - **Centers for Medicare and Medicaid Services**
    - **Substance Abuse and Mental Health Services Administration**
5. Initiate one new **Prevention Project.** Continue the current **Postpartum Depression, Sibling ADHD/Parental Depression, Reward for Quality, and Behavioral Health and Medical Care Coordination** prevention projects.

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

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6. **Provider Monitoring and Technical Assistance**
  - a. Analyze trends in **Critical Incidents, Funding Source Monitoring, Provider Incidents, and Provider Profiling** and provide technical assistance, as indicated.
  - b. Generate and monitor annual **DPH provider contracts**.
  - c. Continue collaboration with the **Drug Utilization Review Commission**.
  - d. Conduct **retrospective clinical on-site reviews** with all Iowa Plan substance abuse providers and selected mental health providers, including hospitals and Community Mental Health Centers.
    - Complete **annual substance abuse retrospective review summary** and submit with QI Annual Report.
  - e. Write Iowa Plan specific content for Magellan's quarterly **Provider Focus** newsletter.
  - f. Continue to maintain **Provider Services Subcommittee** to collaborate internally between Provider Network and Quality Improvement departments.
7. **Satisfaction Surveys**
  - a. Complete two rounds of **Client Satisfaction Surveys** for DPH substance abuse clients and for Medicaid mental health and substance abuse clients, with Medicaid responses sorted for adults and children/adolescents.
  - b. Conduct one **Provider Satisfaction Survey**.
8. Continue **Magellan staff development and training** efforts including on-site CEUs.
  - a. Assess access to **Spanish-speaking staff** and recruit staff, as indicated.
  - b. Continually monitor **staff orientation** efforts and required **annual trainings**.
  - c. Provide training focus on **recovery and resiliency** as well as **cultural competency**.
9. Continue **website enhancement** and **interactive functionality**.
10. Participate in Magellan's **annual policy review**. Customize policies where indicated.
11. Continue **DHS and DPH oversight** activities including:
  - a. monthly Management and Quality Improvement Committee meetings and twice a month Departments Meetings, including review of notice letters
  - b. delivery of the QI Annual Report, including a Fraud and Abuse Summary, QI Quarterly Reports, and monthly Data Reports

All goals and objectives are reflected in Magellan's QI Workplan for the Iowa Plan.

### **Confidentiality**

Documents associated with the QI Work Plan are maintained confidentially, in accordance with Magellan confidentiality policies.

### **Annual Evaluation**

Quality improvement activities, indicators, and monitors are reviewed, evaluated, and revised through the Annual Quality Assurance and Performance Improvement Report, as outlined in the QI Program Description. Evaluation includes two years of trended data (where available) and analysis of impact on clinical care and service. The evaluation identifies strengths and opportunities for improvement and assesses the overall effectiveness of the QI Program in improving the quality of care and services.

### **Review and Approval**

The QI Work Plan is subject to annual review and approval. The Iowa QI Committee reviews and approves the QI Work Plan. After QI Committee approval, the QI Work Plan is forwarded to Magellan's corporate National Quality Committee (NQC) for review and recommendations. The QI Work Plan is updated during the year, as necessary. Signatures of the chairpersons of the QI Committee and chairpersons of the corporate NQC indicate approval of the QI Work Plan.

### **Schedule of Activities**

See the following pages for a schedule of QI monitoring and reporting. See the attached QI Work Plan for specific performance goals and measures.

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

QI Activities	Objective	Responsible Person/ Committee	Target/ Completion Date	Magellan Committee
<p><b>2007-2008 QI Program Evaluation</b></p> <p>Annual Quality Assurance Report</p>	<p>Document and trend key quality improvement indicators, activities, and opportunities for improvement. Include:</p> <ul style="list-style-type: none"> <li>• 2007-08 QI Program Description and 2008-09 QI Program Description draft</li> <li>• Medicaid Community Reinvestment Summary</li> <li>• Substance Abuse Retrospective Review Summary</li> </ul>	<p>Quality and Compliance Director</p> <p>QI Specialists</p> <p>QI Committee</p>	<p>Deliver to DHS and DPH August 29, 2008.</p> <p>Submit to QI Committee for approval September 17, 2008.</p> <p>Submit to National Quality Director for NQC approval following QI Committee approval.</p>	<p>NQC</p>
<p><b>2008-2009 QI Program Description</b></p>	<p>Describe Iowa QI Program. Include:</p> <ul style="list-style-type: none"> <li>• contract requirements</li> <li>• accreditation and regulatory requirements</li> <li>• Magellan requirements for Care Management Centers</li> <li>• opportunities for improvement identified through 2007-08 Annual Report</li> </ul>	<p>Quality and Compliance Director</p> <p>QI Committee</p>	<p>Submit draft version to DHS and DPH August 29, 2008 as attachment to Annual Report.</p> <p>Submit to QI Committee for approval September 17, 2008.</p> <p>Submit to National Quality Director for NQC approval following QI Committee approval.</p>	<p>NQC</p>

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

QI Activities	Objective	Responsible Person/ Committee	Target/ Completion Date	Magellan Committee
<p><b>2008-2009 QI Work Plan</b></p>	<p>Specify implementation and monitoring of QI Program Description activities.</p> <p>Submit QI Work Plan updates to QI Committee each month and review performance to-date and opportunities for improvement.</p>	<p>Director of Operations</p> <p>General Manager</p> <p>Quality and Compliance Director</p> <p>QI Specialists</p> <p>QI Committee</p>	<p>Submit draft version to DHS and DPH August 29, 2008 as attachment to Annual Report.</p> <p>Submit to QI Committee for Approval September 17, 2008</p> <p>Submit to National QI Director for NQC approval following QI Committee approval.</p> <p>Submit with QI Quarterly Reports</p>	<p>NQC</p>
<p><b>QI Quarterly Reports</b></p>	<p>Document all QI Program activities and performance toward goals.</p>	<p>Quality and Compliance Director</p> <p>QI Specialists</p> <p>QI Committee</p>	<p>Submit to DHS and DPH 60 days following the last day of the quarter:</p> <ul style="list-style-type: none"> <li>• November 29, 2008</li> <li>• March 1, 2009</li> <li>• May 30, 2009</li> <li>• August 29, 2009</li> </ul> <p>Submit to QI Committee</p> <p>Submit to National Quality Director for NQC</p>	<p>NQC</p>

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

<b>QI Activities</b>	<b>Objective</b>	<b>Responsible Person/ Committee</b>	<b>Target/ Completion Date</b>	<b>Magellan Committee</b>
<b>Monitor Performance Indicators</b>	Assure appropriate services to members and to families and providers.  Meet Iowa Plan and Magellan requirements	Chief Clinical Officer  Director of Operations  General Manager  Medical Director  Quality and Compliance Director  QI Specialists  QI Committee	Monitor monthly in QI Committee.  Submit Magellan Core Performance Indicators each month.  Submit with QI Quarterly Reports: <ul style="list-style-type: none"> <li>• November 29, 2008</li> <li>• March 1, 2009</li> <li>• May 30, 2009</li> <li>• August 29, 2009</li> </ul>	
<b>Review/ Implement Magellan Policies</b>	Conduct ongoing policy review.  Customize policies as required by Iowa Plan contract requirements.	Quality and Compliance Director  QI Committee	On-going  Review in QI Committee	Magellan Compliance Committee
<b>Review and Approve Iowa Plan Mental Health Utilization Management Guidelines</b>	Conduct annual review.  Implement criteria as approved.	Chief Clinical Officer  Medical Director  Utilization Management Subcommittee  Clinical Advisory Committee  QI Committee	November 2008	National Clinical Management Committee

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

<b>QI Activities</b>	<b>Objective</b>	<b>Responsible Person/ Committee</b>	<b>Target/ Completion Date</b>	<b>Magellan Committee</b>
<b>Accreditation</b>	Maintain URAC accreditation.  Maintain Limited Insurance Organization licensure through Iowa Insurance Division.	Chief Clinical Officer  Director of Operations  General Manager  Medical Director  Quality and Compliance Director	On-going	NQC
<b>Regulatory Compliance</b>	Participate in External Quality Review.  Participate in CMS review.  Participate in SAMHSA review.	Chief Clinical Officer  Director of Operations  General Manager  Medical Director  Quality and Compliance Director	EQR likely in February 2009: <ul style="list-style-type: none"> <li>• Pre-visit materials likely due September/October 2008</li> </ul> SAMHSA (CSAT) review in December 2008  CMS as scheduled.	
<b>State Initiatives</b>	Participate in DHS and DPH initiatives, as requested: Child Welfare redesign, Co-Occurring Academy, IME collaboration, Mental Health redesign, NIATx/STAR-SI, RWJ Financing Strategies	General Manager  Chief Clinical Officer  Medical Director Quality and Compliance Director	As requested	

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

QI Activities	Objective	Responsible Person/ Committee	Target/ Completion Date	Magellan Committee
<b>Performance Improvement Projects</b>	Continue current projects: <ul style="list-style-type: none"> <li>• Behavioral Health and Medical Care Coordination</li> <li>• Peer Support Services</li> </ul>	Chief Clinical Officer  General Manager  Medical Director  Quality and Compliance Director  QI Committee	On-going	
<b>Member Materials - Annual Notification</b>	Mail required annual notice to Medicaid enrollees through newsletter.	Consumer/ Family Advocate  Operations Director  Quality and Compliance Director  Member Services Subcommittee  Consumer/Family Advisory Committee	Discuss with Consumer/Family Advisory Committee by April 2009  Complete by July 2009	

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

QI Activities	Objective	Responsible Person/ Committee	Target/ Completion Date	Magellan Committee
<b>Member Materials - Client Handbook</b>	Review handbook annually and revise as needed.	Consumer/ Family Advocate  Operations Director  Quality and Compliance Director  Member Services Subcommittee  Consumer/Family Advisory Committee	Discuss with Consumer/Family Advisory Committee by April 2009  Complete by July 2009	
<b>Member Materials - Provider Directory</b>	Review directory annually and revise as needed.	Area Contract Manager  Consumer/Family Advocate  Quality and Compliance Director  Member Services Subcommittee  Consumer/Family Advisory Committee	Discuss with Consumer/Family Advisory Committee by April 2009  Complete by July 2009	

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

QI Activities	Objective	Responsible Person/ Committee	Target/ Completion Date	Magellan Committee
<b>Prevention</b>	Continue current projects: <ul style="list-style-type: none"> <li>• ADHD/ Depression</li> <li>• Post-Partum Depression</li> <li>• Reward for Quality</li> <li>• Behavioral Health and Medical Care Coordination</li> </ul> Initiate new prevention project for 2008-09 contract year.	Chief Clinical Officer  Medical Director  Quality and Compliance Director  UM Subcommittee  QI Committee	Review each project quarterly in QI Committee  Submit proposed new project to DHS and QI Committee by September 2008	
<b>Performance Measures</b>	Initiate Performance Measures to better understand trends and to identify potential problems.	Chief Clinical Officer  Director of Operations  General Manager  Medical Director  Quality and Compliance Director  QI Specialists  QI Committee	Monitor monthly in QI Committee	
<b>Innovation Plan</b>	Support recovery and resiliency in all activities through implementation of Innovation Plan	Consumer/Family Advocate  Quality and Compliance Director  Recovery/Resiliency Workgroup	On-going	

**Magellan Behavioral Care of Iowa/Magellan Health Services  
Iowa Plan QI Work Plan Overview 2008 - 2009**

<b>QI Activities</b>	<b>Objective</b>	<b>Responsible Person/ Committee</b>	<b>Target/ Completion Date</b>	<b>Magellan Committee</b>
<b>Cultural Competence Workplan</b>	Support cultural competency in all activities through implementation of Cultural Competence Workplan	Clinical Learning Lead  Quality and Compliance Director  Cultural Competence Workgroup	On-going	

**MAGELLAN HEALTH SERVICES**

/

**MAGELLAN BEHAVIORAL CARE OF IOWA**

**IOWA CARE MANAGEMENT CENTER**

**JULY 2008 - JUNE 2009**

**QUALITY IMPROVEMENT WORK PLAN**

for the

**IOWA PLAN FOR BEHAVIORAL HEALTH**



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**TEMPLATE**

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>COVERED LIVES</b>					
<b>Membership</b>	Total of all Medicaid enrolled clients:	N/A	- Budgeted: IUR - Actual: report named iaplancaprec.xls - cap payments	Monthly	Member Services
Time Frame: Actual:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>ACCESS AND AVAILABILITY</b>					
<b>Timeliness of Telephone Access</b>	<b>Average Speed of Answer (ASA):</b> For all calls answered, this is the average number of seconds that a caller waited to be answered, for the reporting period. <b>Numerator:</b> The number of seconds between first ring and live answer; <b>Denominator:</b> The number of calls answered during the reporting month. - Includes all clients who call the Iowa Plan client number	CSA <= 30 seconds CM <= 60 seconds	- Care Teams: report ID IACS04 - Client Services: report ID IACS04	Monthly	Member Services
Time Frame: Client Services: Care Teams:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Call Abandonment</b>	<b>Call Abandonment Rate (CAR):</b> Percent of calls that were offered, but the caller elected to hang up before being answered. <b>Numerator:</b> Number of incoming calls that are terminated by caller prior to being answered; <b>Denominator:</b> Number of incoming calls for the reporting period. - Includes all clients who call the Iowa Plan client number	5% or less – NCQA standard	- Care Teams: report ID IACS04 - Client Services: report ID IACS04	Monthly	Member Services
Time Frame: Client Services: Care Teams:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Accessibility of Behavioral Healthcare Services</b>	<p><b>A. <u>Wait Times for Initial Appointments:</u></b> Assessment of access to the Medicaid mental health and substance abuse provider network by maintaining waiting times within standard. Sample of Medicaid mental health and substance abuse providers for:</p> <ul style="list-style-type: none"> <li>- Emergency</li> <li>- Urgent Non-Emergency</li> <li>- Persistent Symptoms</li> <li>- Routine Services</li> </ul>	<p><b>Emergency:</b> within 15 minutes of presentation at a service delivery site  <b>Urgent Non-Emergency:</b> within 1 hr of presentation at a service delivery site or within 24 hrs of telephone contact with provider or MBCI  <b>Persistent Symptoms:</b> within 48 hrs of reporting symptoms  <b>Routine Services:</b> within 4 weeks of the request for appointment</p>	Non Incentive/ Penalty Performance Indicator; QI survey of Medicaid mental health and substance abuse providers and retrospective review data	Quarterly	Utilization Management

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Accessibility of Behavioral Healthcare Services (con't)</b>	<p><b>C. <u>Availability of Evening and Weekend Appointments:</u></b> Assessment of access to provider network after regular business hours. Sample of mental health and substance abuse providers for:</p> <ul style="list-style-type: none"> <li>- Evening</li> <li>- Weekend</li> <li>- Medicaid Mental Health</li> <li>- Medicaid Substance Abuse</li> <li>- DPH Substance Abuse</li> </ul>	Monitor Only	QI survey of mental health providers and retrospective review data	Quarterly	Utilization Management

Time Frame:  
Performance:

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>UTILIZATION MANAGEMENT</b>					
<b>Penetration</b>	This definition / calculation provides an accumulative monthly percentage of the number of unique members that are treated at any level of care during the contract year. <b>Numerator:</b> Unduplicated number of enrollees receiving at least one service reimbursed by MBC of Iowa (includes mental health and substance abuse services reimbursed for Medicaid enrollees) <b>Denominator:</b> Unduplicated number of enrollees - Medicaid Mental Health and Substance Abuse	>=13.5%	Monitoring Performance Indicator #11 - Claims data and eligibility data	Contract Year-to-Date	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Residential Substance Abuse Utilization</b>	<b>A. Residential Admits per 1,000:</b> This definition / calculation provides an annualized rate of substance abuse residential admissions per month, based on utilization each month. <b>Numerator:</b> Number of Medicaid Substance Abuse Residential admissions during the reporting period (month) x (365 / Number of days in the reporting period); <b>Denominator:</b> Membership for the reporting period /1000	Monitor Only	IAAU01	Monthly	Utilization Management
Time Frame:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Residential Substance Abuse Utilization (con't)</b>	<p><b>B. Residential Average Length of Stay:</b> Provides an arithmetic mean of the number of days that members' spend in a Medicaid Substance Abuse residential level of care.</p> <p><b>Numerator:</b> Number of Medicaid Substance Abuse Residential days used by patients who were discharged during the reporting period;</p> <p><b>Denominator:</b> Number of discharges from Medicaid Substance Abuse Residential during the reporting period.</p> <p>- This definition / calculation provides an average;            - Requires discharge during the reporting period.</p>	Monitor Only	IAAU10	Monthly	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Inpatient Utilization</b>	<p><b>A. Inpatient Admits per 1,000:</b> This definition / calculation provides an annualized rate of inpatient admissions per month, based on utilization each month.</p> <p><b>Numerator:</b> Number of Inpatient admissions during the reporting period (month) x (365 / Number of days in the reporting period);</p> <p><b>Denominator:</b> Membership for the reporting period /1000</p>	Monitor Only	IAAU01	Monthly	Utilization Management
Time Frame:					
Time Frame:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Inpatient Utilization (con't)</b>	<p><b>B. Days per 1,000:</b> This definition / calculation provides an annualized rate of inpatient days per reporting period (month), based on utilization data.</p> <p><b>Numerator:</b> Number of Inpatient days authorized during the reporting period (month) x (365 / Number of days in the reporting period);</p> <p><b>Denominator:</b> Membership for the reporting period / 1000.</p> <ul style="list-style-type: none"> <li>- This definition / calculation provides an annualized rate, based on utilization each month;</li> <li>- Does not require either admission or discharge during the month</li> </ul>	Monitor Only	Ad-hoc monthly report	Monthly	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Inpatient Utilization (con't)</b>	<p><b>C. Average Length of Stay:</b> Provides an arithmetic mean of the number of days that members' spend in the hospital.</p> <p><b>Numerator:</b> Number of IP days used by patients who were discharged during the reporting period;</p> <p><b>Denominator:</b> Number of discharges from IP during the reporting period.</p> <ul style="list-style-type: none"> <li>- This definition / calculation provides an average;</li> <li>- Requires discharge during the reporting period.</li> </ul>	<ul style="list-style-type: none"> <li>- Medicaid Mental Health: &lt;= the 12 day average under fee-for-service</li> <li>- Medicaid Substance Abuse: Monitor Only</li> </ul>	IAAU10	Monthly	Utilization Management
Time Frame:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Inpatient Utilization (con't)</b>	<b>D. Inpatient Penetration:</b> This definition / calculation provides an accumulative monthly rate of the number of unique members that are treated in inpatient settings for the calendar year to date. <b>Numerator:</b> Number of patients that used IP services for the first time year to date during the reporting month; <b>Denominator:</b> Number of members. - Each member is counted once during each calendar year; - The monthly rates represent contract to date penetration	Monitor only	Monitoring Performance Indicator #11, ad-hoc query	Contract Year-to-Date	Utilization Management
Time Frame: Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Partial Hospital Utilization</b>	<b>A. Admissions per 1,000:</b> This definition / calculation provides an annualized rate of partial hospitalization admissions per month, based on utilization each month. <b>Numerator:</b> Number of Partial Hosp. Admissions during the reporting period x (365 / Number of days in the reporting period); <b>Denominator:</b> Membership for the reporting period / 1000. - Medicaid Mental Health only - This definition / calculation provides an annualized rate, based on utilization each month.	Monitor Only	IAAU01	Monthly	Utilization Management
Time Frame: Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Partial Hospital Utilization (con't)</b>	<p><b>B. Visits per 1,000:</b> This definition / calculation provides an annualized rate of Partial Hospital days per reporting period (month), based on monthly utilization data.</p> <p><b>Numerator:</b> Number of Partial Hosp. visits used for the month x (365 / Number of days in the reporting period);.</p> <p><b>Denominator:</b> Membership for the reporting period / 1000.</p> <ul style="list-style-type: none"> <li>- Medicaid Mental Health only</li> <li>- This definition / calculation provides an annualized rate, based on utilization each month.</li> <li>- Does not require either admission or discharge during the month.</li> </ul>	Monitor Only	Ad-hoc query, claims data	Monthly	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Partial Hospital Utilization (con't)</b>	<p><b>C. Penetration Rate:</b> This definition / calculation provides an accumulative monthly rate of the number of unique members that are treated in Partial Hospital settings for the calendar year to date.</p> <p><b>Numerator:</b> Number of patients that used Partial Hosp. Services for the first time year to date during the reporting month;</p> <p><b>Denominator:</b> Number of members.</p> <ul style="list-style-type: none"> <li>- Medicaid Mental Health only</li> <li>- Each member is counted once during each contract year;</li> <li>- The monthly rates represent year to date penetration</li> </ul>	Monitor Only	Monitoring Performance Indicator #11	Contract Year-to-Date	Utilization Management
Time Frame:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
Outpatient Utilization	<p><b>A. Outpatient Visits Per 1,000:</b> This definition / calculation provides an annualized rate of Outpatient visits that occurred during the reporting period (month), based on monthly utilization data.</p> <p><b>Numerator:</b> Number of Outpatient visits used during the reporting month x (365) / (Number of days in reporting period);</p> <p><b>Denominator:</b> Membership for the reporting period / 1000</p> <p>- Does not require either admission or discharge during the month</p>	<p>- Medicaid Mental Health: 1058.09* visits per 1,000 (established baseline from 1998 contract period)</p> <p>- Medicaid Substance Abuse: Monitor Only</p>	Claims Data – 3 months claim lag required	Monthly	Utilization Management
Time Frame: Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
Outpatient Utilization (con't)	<p><b>B. Outpatient Penetration Rate:</b> This definition / calculation provides an accumulative monthly rate of the number of unique members that are treated in outpatient settings for the calendar year to date.</p> <p><b>Numerator:</b> Number of patients that used OP services for the first time year to date during the reporting month;</p> <p><b>Denominator:</b> Number of members.</p> <p>- Each member is counted once during each contract year;</p> <p>- The monthly rates represent year to date penetration</p>	Monitor only	Monitoring Performance Indicator #11, Ad-hoc query	Contract Year-to-Date	Utilization Management
Time Frame: Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>30-Day Inpatient Readmission</b>	This definition / calculation provides a rate of patients that are discharged from IP care and are readmitted within 30 days of discharge. <b>Numerator:</b> Number of IP discharges during the calendar month prior to the reporting month that were subsequently authorized for admission to IP care within 30 days (i.e., 30 days of the discharge date); <b>Denominator:</b> Total number of IP discharges during the calendar month prior to the reporting month. - Requires discharge from IP/level IV or IVD care during the month prior to the reporting month; - Requires an IP/level IV or IVD admission.	- Medicaid Mental Health: <= 15% - Medicaid Substance Abuse: Monitor Only	Incentive Performance Indicator #1 for MH/SA	Monthly	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>7-Day Ambulatory Follow-up</b>	This definition / calculation provides a percentage of patients that were discharged from inpatient care who received other treatment within 7 days of discharge date (Mental Health only). <b>Numerator:</b> Number of discharges from an inpatient setting (whether or not the inpatient hospitalization was authorized by MBCI at the time of discharge) during the contract period for whom information from a network provider reflects a subsequent treatment service within 7 calendar days of the discharge date <b>Denominator:</b> Number of discharges from an inpatient setting during the contract period (whether or not the inpatient hospitalization was authorized by MBCI at the time of discharge) - Medicaid Mental Health only	90% of persons discharged from IP care will receive other treatment services within 7 days of discharge date (Mental Health only)	Incentive Performance Indicator #6	Monthly	Utilization Management
Time Frame:					
Performance:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Over/Under Utilization</b>	Evaluate potential under and over utilization of services and the causes of such.  - Medicaid Mental Health and Substance Abuse combined - Specific to rural areas - Trend by county and regionally	Monitor Only	IAUT02	Quarterly	Utilization Management
Time Frame: Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Care Manager Audits</b>	At a minimum the following essential elements are reviewed on a sample of care management records to evaluate clinical and administrative effectiveness of the authorization process: <u>Core Clinical:</u> - Chief Complaint Documented - Precipitant and Proximal Event (s) (Why Now) - Risk Assessment (Suicidality & Homocidality) - Current Signs and Symptoms - Prior Treatment History (including problems, allergies, medications) - Treatment Plan and Goals - Current Medication - Support Systems/Social Supports - 5 Axis DSM IV documented - Discharge Planning/Specific Aftercare Plan <u>Core Authorization:</u> - Appropriate criteria identified - Level of care/authorization decision justified and appropriate - Appropriate days authorized - Case referred to physician advisor for review OK within time standards. <u>Core Service/Administrative</u> - Initial authorization decision rendered within established time frame (of receipt of necessary clinical information) (Emergent, Urgent, Routine) - Concurrent review conducted with established time frame (of receipt of necessary clinical information)	100% of care managers meet >= 90% accuracy and >=90% overall accuracy	Care Management Audit Tools	Quarterly	Utilization Management
Time Frame: Performance: Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Timeliness of UM Decisions</b>	Assess the timeliness of UM decisions by auditing a random sample of case management records.  <b>Numerator:</b> Number of care management records that document UM decisions were made within time standard; <b>Denominator:</b> Number of care management records that were reviewed.	100% of initial admission and concurrent reviews are performed with 24 hours of notification.	Care Management Audit Tools	Quarterly	Utilization Management
Time Frame: Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Consistency of UM Application/ Inter-rater reliability</b>	To demonstrate standardized care decisions for members by monitoring and maintaining a high level of inter-clinician agreement	>= 90% agreement on UM decisions	Care Management Audit Tools	Quarterly	Utilization Management
Time Frame: Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Critical Incident and QI Occurrence Reporting</b>	Total number of identified critical incidents reported in the month for the following categories (RFP requirement):	N/A	Reports from providers; critical incident log	Monthly	Utilization Management
Time Frame:					
		<b>Medicaid MH</b>	<b>Medicaid SA</b>	<b>DPH SA</b>	
	Completed Suicide				
	Completed Homicide				
	Medical Death				
	Suicide Attempt				
	Self-Mutilation/Self-Assault				
	Assault on others				
	Other Dangerous Behavior				
	Sexual Abuse or Allegation thereof (while in treatment setting)				
	Use of illicit drugs/alcohol while in an inpatient, residential or halfway house facility				
	Abuse of over the counter medications or toxic substances (i.e. glue, inhalants, etc.) while in an inpatient, residential or halfway house facility				
	Leaving a 24-hour facility against medical advice (AMA/ASA)				
	Inpatient/Subacute/23 hr.				
	Residential				
	Escape from a locked facility				
	Unauthorized departure from a 24-hour facility pursuant to a Court Order				
	Incident related to seclusion and/or restraint				
	Other				
	<b>Total</b>				

Note:  
 Medicaid MH/SA data pulled from AS400.  
 DPH SA AMA data pulled from SARS. Discharge Reason = Client Left  
 DPH SA AMA data reported on a one month lag.

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Critical Incident and QI Occurrence Reporting</b>	Total number of identified critical incidents reported in the month for the following categories (RFP requirement):	N/A	Reports from providers; critical incident log	Monthly	Utilization Management
	<b>Critical Incidents - Contract Year-to-Date</b>				
		<b>Medicaid MH</b>	<b>Medicaid SA</b>	<b>DPH SA</b>	
	Completed Suicide				
	Completed Homicide				
	Medical Death				
	Suicide Attempt				
	Self-Mutilation/Self-Assault				
	Assault on others				
	Other Dangerous Behavior				
	Sexual Abuse or Allegation thereof (while in treatment setting)				
	Use of illicit drugs/alcohol while in an inpatient, residential or halfway house facility				
	Abuse of over the counter medications or toxic substances (i.e. glue, inhalants, etc.) while in an inpatient, residential or halfway house facility				
	Leaving a 24-hour facility against medical advice (AMA/ASA)				
	Inpatient/Subacute/23 hr.				
	Residential/PMIC				
	Escape from a locked facility				
	Unauthorized departure from a 24-hour facility pursuant to a Court Order				
	Incident related to seclusion and/or restraint				
	Other				
	<b>Total</b>				

Note:  
 Medicaid MH/SA data pulled from AS400.  
 DPH SA AMA data pulled from SARS. Discharge Reason = Client Left

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Clinical Practice Guidelines</b>	Educate providers on Clinical Practice Guidelines and encourage adherence to guidelines	N/A	Report of education activities	Annual	Utilization Management
Time Frame:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Coordination of Behavioral Health Services with Primary Care Physicians</b>	This indicator is a measure of the frequency with which practitioners communicate with PCPs regarding patients that they have in common.  <b>Numerator:</b> The number of provider / practitioner charts or treatment records (reviewed during the reporting period) where communication between provider / practitioner and PCP is documented; <b>Denominator:</b> The number of charts / treatment records that were reviewed through the quality retrospective review process during the reporting period. - Medicaid Mental Health	Monitor Only	Retrospective record reviews	Quarterly	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>MEMBER SERVICES</b>					
<b>Grievance Responsiveness</b>	<b>A. Grievances (Complaints) per 1,000:</b> This definition / calculation provides a rate of the number of grievances per 1,000 members. <b>Numerator:</b> Number of grievances x (365 / number of days in the reporting period); <b>Denominator:</b> Membership for the reporting period / 1000.	0.5 per 1,000 or less	IACS01	Monthly	Member Services
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Grievance Responsiveness (con't)</b>	<b>B. Percent of Grievance that met Turn-around Time Standard:</b> This definition / calculation provides the percent of grievances which were processed within the time standard. <b>Numerator:</b> Number of grievances processed during the reporting period within standard x 100; <b>Denominator:</b> Total number of grievances received during the reporting period.	100% resolved within 14 days	IACS01	Monthly	Member Services
Time Frame:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Grievance Responsiveness (con't)</b>	<p><b>C. Mean time to grievance resolution:</b> This definition / calculation provides the average length of time between receipt and resolution of grievances.</p> <p><b>Numerator:</b> Total time taken to resolve all grievances during the reporting period; <b>Denominator:</b> The total number of grievances that were resolved during the reporting period.</p>	Monitor Only	IACS01	Monthly	Member Services
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Appeals Responsiveness</b>	<p><b>A. Percent of appeals which met time standard for review:</b></p> <p><b>Numerator:</b> Number of appeals which met time standard during the reporting period; <b>Denominator:</b> Total number of appeals received during the reporting period. Count those in the month the appeal was made, not by date of service or any other time period.</p>	<p>- &gt;= 90% of Expedited appeals will be resolved verbally within 3 business days of receipt of request - 100% of Standard appeals will be resolved within 14 days of receipt of request</p>	Appeal Log, Ad-hoc report	Monthly	Member Services
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Appeals Responsiveness (con't)</b>	<p><b>B. Percent of appeals that led to Overturn of Decision:</b></p> <p><b>Numerator:</b> Number of appeals overturned during the reporting period; <b>Denominator:</b> Number of appeals decided during reporting period.</p>	TBD	Appeal log and IAAU06	Monthly and Contract Year-to-Date	Member Services
Time Frame:					
Performance:					
Rolling Period to Date:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Clinical Non-authorizations per 1,000</b>	This definition / calculation is a projection, based on current number of non-authorizations, of the number of annualized clinical non-authorizations per 1,000 members. <b>Numerator:</b> Number of clinical non-authorizations during the reporting period x (365 / number of days in the reporting period); <b>Denominator:</b> Membership for the reporting period / 1000. -- Count non-authorizations in the month made, not by date of service or any other time period	MH Clinical <= 7.40 MH Admin. <= 7.00 SA Clinical <= 1.10 SA Admin. <= 1.10	Non-authorization log	Monthly	Utilization Management

Time Frame:  
Performance per 1,000:

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Clinical Authorizations per 1,000</b>	This definition / calculation is a projection, based on current number of authorizations, of the number of annualized clinical authorizations per 1,000 members. <b>Numerator:</b> Number of clinical authorizations during the reporting period x (365 / number of days in the reporting period); <b>Denominator:</b> Membership for the reporting period / 1000. - Count authorizations in the month made, not by date of service or any other time period	MH <= 375.00 SA <= 40.20	Authorization data , Ad-hoc query	Monthly	Utilization Management

Time Frame:  
Performance per 1,000:

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Member Requests Change of Provider</b>	<p><b>Requests for change in provider:</b>            This definition / calculation provides the rate of member complaints filed against providers and requests for change of providers.</p> <ul style="list-style-type: none"> <li>- Medicaid Mental Health</li> <li>- Medicaid Substance Abuse</li> <li>- DPH Substance Abuse</li> <li>- Overall</li> </ul>	Monitor Only	Grievance log	Quarterly	Member Services
Time Frame: Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Member Satisfaction</b>	<p><b>A. Written Survey</b>            The percent of respondents that responded positively to "Overall Satisfaction" question</p> <p><b>Numerator:</b> Number of individual respondents that rated overall satisfaction item positively;  <b>Denominator:</b> Total number of respondents that responded to the overall satisfaction item</p> <ul style="list-style-type: none"> <li>- Medicaid Mental Health</li> <li>- Medicaid Substance Abuse</li> <li>- Overall</li> </ul>	>= 85%	Monitoring Performance Indicator #3; Customer and Corporate approved survey and database	Semi-Annually	Member Services
Time Frame: Performance: Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>NETWORK</b>					
<b>Provider Satisfaction</b>	The percent positive response to overall satisfaction with MBC of Iowa.  <b>Numerator:</b> Number of individual respondents that rated the overall satisfaction item positively; <b>Denominator:</b> Total number of respondents that responded to the overall satisfaction item  - Medicaid Mental Health - Medicaid and DPH Substance Abuse - Overall	>= 75% of respondees report overall satisfaction with MBC of Iowa services	Monitoring Performance Indicator #16; Customer/Corporate approved surveys, sampling, methodology and database.	Annually	Professional Provider Review
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Network Adequacy</b>	<b>A. Access:</b> This definition / calculation estimates the coverage of mental health practitioners/providers within the established standards for maximum distance by calculating the percentage of members that are within maximum distance standards of mental health providers.  <b>Numerator:</b> Number of members within the established distance standards of providers; <b>Denominator:</b> Number of members within the region.  - Medicaid Mental Health	<b>Urban Inpatient:</b> 100% within 30 minutes <b>Urban Outpatient:</b> 100% within 45 minutes <b>Rural Inpatient:</b> 100% within 45 miles <b>Rural Outpatient:</b> 100% within 34 miles (RFP requirement)	Monitoring Performance Indicator #10; Geo-Access Maps	Monthly	Professional Provider Review
Time Frame:					
Performance:					

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<b>Network Adequacy (cont.)</b>	<p><b>B. Density:</b> This definition / calculation provides the number of providers per 1000 members within the State.</p> <p><b>Numerator:</b> Number of providers in the State of Iowa;  <b>Denominator:</b> Membership for the reporting period / 1000.</p> <p>- Medicaid Mental Health            - Medicaid and DPH Substance Abuse</p>	Monitor Only	Network database (Geo-Access Reports, etc.)	Annually Calculated at end of contract year	Professional Provider Review
Time Frame: Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Timeliness of Credentialing and Re-Credentialing</b>	<p>Credentialing of all Iowa Plan providers applying for network provider status shall be completed as follows: 60% within 30 days; 100% within 90 days.</p> <p>Completion time shall be tracked from the time all required paperwork is provided to the Contractor until the time a written communication is mailed or faxed to the provider notifying them of the Contractor's determination.</p>	60% within 30 days; 100% within 90 days	Credentialing Tracking System	Quarterly	Professional Provider Review
Time Frame: Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Substance Abuse Discharge Plan Documentation</b>	This definition/calculation identifies the percentage of enrollees being discharged from SA Level III.7,III.5 and III.3 settings for whom a discharge plan was documented on the day of discharge. <b>Numerator:</b> Number of clients who were discharged from SA Level III.7,III.5 and III.3 settings for whom a discharge plan was documented on the day of discharge. <b>Denominator:</b> The total number clients who were discharged from SA Level III.7,III.5 and III.3 settings.	>=90%	Substance Abuse Retrospective Chart Reviews	Quarterly	Utilization Management
Time Frame: Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>14-Day SA Ambulatory Follow-up Post Discharge</b>	This definition/calculation provides the percentage of clients discharged from SA Level III.5 and III.3 settings who received a follow-up SA services within 14 days of discharge. <b>Numerator:</b> Number of clients who were discharged from SA Level III.5 and III.3 settings who received a follow-up SA services within 14 days of discharge. <b>Denominator:</b> The total number clients who were discharged from SA Level III.5 and III.3 settings	Goal = 60% within 14 days (effective 7/1/04)	Incentive Performance Indicator #7, Authorization Data, Claims Data	Monthly	Utilization Management
Time Frame: Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>30-Day Ambulatory Follow-up SA</b>	This definition/calculation provides a percentage of enrollees discharged from SA 24 hour Level of Care (excluding III.1 Halfway House) where there is follow-up within 30 days of discharge.  <b>Numerator:</b> Number of enrollees discharged from SA 24 hour Level of Care (excluding III.1 Halfway House) where there is follow-up within 30 days of discharge. <b>Denominator:</b> Total number of enrollees discharged from SA 24 hour Level of Care (excluding III.1 Halfway House)	Monitor Only	Penalty Performance Indicator 6, Discharges and Claims Data	Monthly	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Dual Diagnosis Enrollee Follow-up</b>	This definition/calculation provides the number of dually diagnosed clients admitted to an MH/SA inpatient level of care or SA residential level of care (excluding Halfway House) and track the follow-up services received within 90 days paid by the Iowa Plan.	Monitor Only	Monitoring Performance Indicator 18, Discharges and Claims Data	Monthly	Utilization Management
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Retrospective Treatment Record Reviews</b>	<b>A. Percent compliance with tool:</b> This calculation determines the percent of retrospective reviews in compliance with the retrospective review tool.  The total number of facilities/providers who were evaluated.  Percentage of compliance with tool.  - Medicaid Mental Health - Medicaid and DPH Substance Abuse	MH > = 85 %      SA > = 85 %	Retrospective treatment record reviews	Quarterly	Utilization Management
Time Frame:					
Performance:					

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>CLAIMS</b>					
<b>Timeliness of Claims Processing</b>	<b>A. Percent of claims processed within 12, 30 and 90 days:</b> Claims shall be paid or denied within the following time periods: - 85% within 12 calendar days - 90% within 30 calendar days - 100% within 90 calendar days Time shall be calculated from the date the claim is received by MBC of Iowa until the date the check or denial letter is mailed to the provider. This standard relates to the payment of claims for Medicaid-funded substance abuse and mental health services as well as SPP-funded services.	- 85% within 12 calendar days - 90% within 30 calendar days - 100% within 90 calendar days	Penalty Performance Indicator #12; Medicaid only	Monthly	Member Services
Time Frame:					
Performance:					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Timeliness of Claims Processing</b>	<b>B. Percent of claims denied:</b> <b>Numerator:</b> Number of claims denied during the reporting month; <b>Denominator:</b> Number of claims processed during the reporting month. - Medicaid Mental Health and Substance Abuse	19% or less	IACL04	Monthly	Member Services
Time Frame:					
Performance:					

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**DPH Substance Abuse Funding Source Monitoring**

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>MBC of Iowa DPH-Funded Population Receiving Services</b>	MBC of Iowa is contractually required to meet certain thresholds for population categories served such as: - Women - Pregnant women - Criminal justice referral source - Unemployed - Prior substance abuse treatment - Race other than Caucasian - Monthly taxable income under \$1000 Each month, MBC of Iowa generates a report that summarizes the number and percent of clients receiving services that fall into these population categories.	- Women: 27.8% - Pregnant: 4.3% - Criminal justice referral source: 63.9% - Unemployed: 30.7% - Race other than Caucasian: 12.5% - Prior substance abuse treatment: 41.3% - Monthly taxable income under \$1000: 65%	Admissions SARS, I-SMART Admissions	YTD	Utilization Management
Time Frame: Women: Pregnant: Criminal justice referral source: Unemployed:		Race other than white: Prior substance abuse treatment: Monthly taxable income under \$1000:			

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>DPH-Funded Services Minimum Client Counts</b>	MBC of Iowa is contractually required to serve a minimum number of DPH-Funded clients each year. MBC of Iowa DPH-Funded providers also have contractual minimum client numbers. Quarterly, MBC of Iowa generates a report that summarizes by DPH-Funded provider the number of DPH-Funded clients served year-to-date. MBC of Iowa reports DPH-Funded minimum client number compliance to IDPH on a quarterly basis.	- Minimum unduplicated number of DPH participants for 7/1/06 – 6/30/07: 19,154	Service SARS, I-SMART Encounters	YTD	Utilization Management
Time Frame: Minimum unduplicated number of DPH participants:					

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**DPH Substance Abuse Funding Source Monitoring**

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Medicaid Service SARS/I-SMART to Medicaid Eligibility</b>	MBC of Iowa and the network providers are contractually required to assure that client services are paid through the correct Medicaid or DPH-Funded funding stream. Quarterly, MBC of Iowa generates a report that cross-checks clients reported on SARS/I-SMART as Medicaid with Medicaid enrollment tapes to confirm Iowa Plan enrollment.	Monitor Only	Service SARS, I-SMART Encounters and Medicaid Enrollment tapes	Quarterly	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: Date MBC of Iowa sent monitoring letter to providers					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>Minimum DPH-Funded Client Counts</b>	MBC of Iowa is contractually required to serve a minimum number of DPH-Funded clients each year. MBC of Iowa DPH-Funded providers also have contractual minimum client numbers. Each month, MBC of Iowa generates a report specific to each DPH-Funded provider that summarizes the number of DPH-Funded clients the provider has served year-to-date.	Monitor Only	Service SARS, I-SMART Encounters	Annually	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: Date MBC of Iowa sent monitoring letter to providers: **					

\*\* At the end of the contract year the Substance Abuse Director personally visits the providers who do not meet minimum numbers.

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Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>DPH-Funded Detox/Acute Inpatient Crosscheck</b>	MBC of Iowa and Network DPH-Funded providers are contractually required to assure that DPH-Funded funding is not used to pay for detoxification or acute hospitalization. Quarterly, MBC of Iowa generates a report for each DPH-Funded provider that lists clients reported as DPH-Funded for whom detox services and/or acute hospitalization were also reported.	Monitor Only	Services SARS, I-SMART Encounters	Quarterly	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: MBC of Iowa monitoring letter sent to the providers					
<b>DPH-Funded IV Drug User Wait Time Crosscheck</b>	MBC of Iowa and DPH-Funded providers are contractually required to assure that IV drug users whose services are supported by DPH-Funded funding are admitted within 14 days of assessment. Quarterly, MBC of Iowa generates a report for each DPH-Funded provider that lists clients reported as DPH-Funded IV drug users for whom the reported wait time for admission to services was longer than 14 days.	Monitor Only	Admissions SARS, I-SMART Admissions	Quarterly	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: MBC of Iowa monitoring letter sent to providers					

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**DPH Substance Abuse Funding Source Monitoring**

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>DPH-Funded Pregnant Women Wait Time Crosscheck</b>	MBC of Iowa and DPH-Funded providers are contractually required to assure that pregnant women whose services are supported by DPH-Funded funding are admitted to treatment within 48 hours of assessment. Quarterly, MBC of Iowa generates a report for each DPH-Funded provider that lists clients reported as DPH-Funded pregnant women for whom the reported wait time for admission to services was longer than two days.	Monitor Only	Admissions SARS, I-SMART Admissions	Quarterly	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: MBC of Iowa monitoring letter sent to providers					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>DPH-Funded Reporting by Ineligible Contractor</b>	MBC of Iowa DPH-Funded contracts are held by a limited number of providers. SARS reporting is monitored to assure that ineligible providers, that is, providers who do not hold DPH-Funded contracts, do not report clients as DPH-Funded. Quarterly, MBC of Iowa generates individual reports for ineligible providers that list clients reported as DPH-Funded.	Monitor Only	Services SARS, I-SMART Encounters	Quarterly	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: MBC of Iowa monitoring letter sent to providers					

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**DPH Substance Abuse Funding Source Monitoring**

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>DPH-Funded Service SARS / I-SMART to Medicaid Eligibility</b>	Because DPH-Funded funding must be the payor of last resort, MBC of Iowa and MBC of Iowa DPH-Funded providers are contractually required to assure that DPH-Funded funding is not used to pay for services in any month in which the client is MBC of Iowa Medicaid enrolled. Quarterly, MBC of Iowa generates a report that cross-checks clients reported on SARS/I-SMART as DPH-Funded with Medicaid enrollment tapes to confirm that the client is not MBC of Iowa Medicaid enrolled.	Monitor Only	Services SARS, I-SMART Encounters and Medicaid Enrollment tapes	Quarterly	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: MBC of Iowa monitoring letter sent to providers					

Measure	Definition	Goal	Data Source	Reporting Interval	Responsible Subcommittee
<b>OWI Screening, Evaluation and Treatment Crosscheck</b>	Because the intent of the 1997 OWI law was for OWI screening and evaluation to be self supporting, such services can not be paid for through DPH-Funded funding. Quarterly, MBC of Iowa generates reports that list clients reported as a DPH-Funded client for whom OWI screening/evaluation was provided without admission to treatment services.	Monitor Only	Admission SARS, I-SMART Admissions	Quarterly	Utilization Management
Time Frame: Number of Providers identified: Number of Clients affected: MBC of Iowa monitoring letter sent to providers					