The State of Louisiana Office of Behavioral Health
Magellan of Louisiana CSoC Program
Annual External Quality Review Technical Report

FINAL REPORT
Review Period: July 1, 2019 to June 30, 2020
Report issued: April 2021

IPRO
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I. Introduction

The State of Louisiana has developed a coordinated system of care (CSoC) for Louisiana's children and youth with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. The CSoC offers an array of Medicaid State Plan and Home and Community-Based Waiver services (HCBS) to children and youth in need of mental health and/or substance use treatment who are deemed clinically and financially eligible.

The CSoC is an evidence-informed approach to family and youth-driven care that enables children to successfully live at home, stay in school, and reduce involvement in the child welfare and juvenile justice systems. The primary goals for CSoC include:

- Reducing the number of children and youth in detention and residential settings;
- Reducing the State of Louisiana's cost of providing services by leveraging Medicaid and other funding sources;
- Increasing access to a fuller array of home- and community-based services that promote hope, recovery, and resilience;
- Improving quality by establishing and measuring outcomes; and
- Improving the overall functioning of these children and their caregivers.[i]

The CSoC program is centered around wraparound agencies (WAAs), located throughout the state. The WAAs develop and implement plans of care (POCs) for the CSoC youth, based upon previously assessed needs. In conjunction with family support organizations (FSOs), appropriate services and supports are provided and are regularly monitored and updated in accordance with changes in members' conditions. The success of the program relies heavily upon POC monitoring by the WAAs.

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that these programs furnish to Medicaid recipients.

In order to comply with these requirements, the Louisiana Department of Health (LDH) contracted with IPRO to assess and report the impact of its Medicaid managed care program and its participating PIHPs on the accessibility, timeliness, and quality of services. Specifically, this report provides IPRO's independent evaluation of the services provided by Magellan of Louisiana's CSoC program (Magellan) for the review period July 1, 2019 – June 30, 2020.

The framework for the assessment is based upon the guidelines and protocols established by CMS, as well as Louisiana state requirements.

The following goals and priorities reflect the state's priorities and areas of concern for the population covered by the CSoC:

- Improve accessibility to care and use of services;
- Improve effectiveness and quality of care;
- Improve cost effectiveness through reducing repeat emergency room (ER) visits, hospitalizations, out-of-home placements, and institutionalizations; and
- Increase coordination and continuity of services.

Areas of EQR oversight are addressed in this report:

- Validation of selected CSoC performance measures;
- Validation of the CSoC Performance Improvement Project (PIP); and
- Compliance review.

II. Validation of Performance Measures

Performance measure validation for the review period July 1, 2019, to June 30, 2020, was ongoing during the writing of this report. Performance measure validation from the 2018–2019 ATR is duplicated here.

Performance measures provide information regarding directions and trends in the aspects of care and service being measured. The information is used to focus and identify future quality activities and direct interventions to improve quality of care and services. Performance measures are tracked and trended, and information will be used by the Office of Behavioral Health (OBH) to develop future quality activities.

IPRO, in consultation with the OBH, selected five (5) performance measures reported by Magellan of Louisiana CSoC., for the period April 1, 2019, through June 30, 2019. The Coordinated System of Care (CSoC) program was developed by the State of Louisiana for children and youth with significant behavioral health challenges, with the ultimate goal of preventing out of home placement through the provision of home and community based services aimed at promoting positive behavioral health outcomes. The CSoC program is managed by Magellan; the program is heavily focused upon the activities performed and provided by Wrap-Around Agencies (WAAs), of which there were nine (9) across the state for this contract year. Comprehensive needs assessments, care plan development and modification, and service coordination are largely the responsibility of the WAAs and Family Support Organizations (FSOs). The measures selected for validation are representative of the care plan oversight and service monitoring required by Magellan, the WAAs, and FSOs to insure the success of the program.

The five selected measures were:

1. Follow-Up After Hospitalization for Mental Illness (FUH);
2. Number and percent of participants whose level of care determination was made by a qualified evaluator (LOC3);
3. Number and percent of providers initially meeting licensing and training requirements prior to furnishing waiver services (QP 1);
4. Number and percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care (POC 06); and
5. Utilization of Outpatient Services (QM 14).

Validation Methodology

For each measure selected for validation, IPRO requested the universes of cases that met numerator compliance for the 4/1/19 - 6/30/19 review period. Magellan uploaded the universes for each of the five measures to IPRO's secure File Transfer Protocol (FTP) site in December 2019. From the universes, IPRO randomly sampled 30 cases for validation, with the exception of measure QP 1 because there were only nine facilities for which site reviews were conducted within the review period. For the QP1 measure, the entire universe was selected for validation.

Once the sample was selected, IPRO requested that Magellan provide the documentation that would meet numerator compliance for each case in the measure. The five measures and the data sources used to evaluate compliance are noted below.

Measure 1: Follow-Up After Hospitalization for Mental Illness (FUH)

HEDIS Description: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days after discharge.
- The percentage of discharges for which the member received follow-up within 7 days after discharge.

Data Source: HEDIS data repository containing discharge dates and outpatient follow-up visit dates.

Denominator: An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm.

Numerator: Two different numerators are considered:

- 7-day: A follow-up visit with a mental health practitioner within 30 days after discharge.
- 30-day: A follow-up visit with a mental health practitioner within 30 days after discharge.

Reported Rates: The following data were reported for HEDIS RY 2019 (reporting period January 1, 2018–December 31, 2018; **Table 1**).

Table 1: Follow-Up After Hospitalization for Mental Illness Rates

Measure	Denominator	Numerator	HEDIS MY 2019
Follow-Up After Hospitalization for Mental Illness (FUH): 7 day follow-up	374	199	53.2%
Follow-Up After Hospitalization for Mental Illness (FUH): 30 day follow-up	374	273	73.0%

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

Validation Findings: Validation findings are reported as passed or failed:

- Passed = 30
- Failed = 0

Measure 2: Number and Percent of Participants whose Level of Care Determination was Made by a Qualified Evaluator (LOC 3)

Data Source: Proof of licensure as a behavioral health specialist.

Denominator: Member sample (*n* = 30).

Numerator: Number of members whose level of care (LOC) determination made by a qualified evaluator.

Results Reported:
The following results were reported by Magellan for the period July 1, 2018–June 30, 2019 (**Table 2**).

Table 2: Number and Percent of Participants whose Level of Care Determination was Made by a Qualified Evaluator

Measure	Reviewed	Met	Percent Compliant
Number and percent of participants whose level of care determination was made by a qualified evaluator (LOC 3)	388	388	100%

LOC: level of care.

Validation Findings: IPRO reviewed 30 files and made the following determination:
Passed = 30
Failed = 0

Measure 3: Number and Percent of Providers Initially Meeting Licensing and Training Requirements prior to Furnishing Waiver Services (QP1)

Data Source: Magellan Provider Monitoring and Scoring tool.

Denominator: A member sample (*n* = 30) was requested of providers furnishing waiver services. The universe of these providers was 9, which served as the denominator.

Numerator: Number of providers initially meeting licensing and training requirements prior to furnishing waiver services.

Validation Findings: IPRO reviewed 9 files and made the following determination:
Passed= 9
Failed = 0

Measure 4: Number and Percent of Participants who Received Services in the Type, Amount, Duration, and Frequency Specified in the Plan of Care (POC 06)

Data Source: Member Plan of Care Report.

Denominator: Member sample (*n* = 30).

Numerator: Number of members who received services according to the plan of care.

Results Reported: The following results were reported by Magellan for the period July 1, 2018–June 30, 2019 **(Table 3**).

Table 3: Participants Receiving Services by Month

Month	Numerator	Denominator	Percent Compliant
July 2018	2,200	2,306	95.40%
August 2018	2,188	2,263	96.69%
September 2018	2,171	2,272	95.55%
October 2018	2,219	2,314	95.89%
November 2018	2,233	2,333	95.71%
December 2018	2,272	2,340	97.09%
January 2019	2,262	2,325	97.29%
February 2019	2,262	2,324	97.33%
March 2019	2,240	2,305	97.18%
April 2019	2,233	2,290	97.51%
May 2019	2,227	2,284	97.50%
June 2019	2,212	2,277	97.15%

Validation Findings: IPRO reviewed 30 files and made the following determination:
Passed= 29
Failed = 1

Measure 5: Utilization of Outpatient Services (QM 14)

Data Source: Magellan's Monthly Utilization Data Report.

Denominator: Member sample (*n* = 30).

Numerator: Members with an outpatient service during the review period.

Validation Findings: IPRO reviewed 30 files and made the following determination:
Passed= 30
Failed = 0

Overall Validation Findings and Recommendations

Overall, the validation process and findings indicate that Magellan accurately calculates its LDH-required performance measures. The documentation was easy to navigate and the requirements for numerator compliance were clearly noted. Recommendations can be found in **Section VI**.

III. Validation of Performance Improvement Projects

PIPs engage PIHP care and quality managers, providers, and members as a team with the common goal of improving patient care. The PIHP begins the PIP process by targeting improvement in annual baseline performance indicator rates and identifying drivers of improved evidence-based performance. The next step is to identify barriers to quality of care and to use barrier analysis findings to inform interventions designed to overcome the barriers to care. Interventions are implemented and monitored on an ongoing basis using quarterly and/or monthly intervention tracking measures (ITMs). Declining or stagnating ITM rates signal the need to modify interventions and rechart the PIP course. Positive ITM trends are an indication of robust interventions.

IPRO collects performance indicator data and ITM data reported by the plans in annual PIP reports, quarterly PIP reports, and monthly PDSA run chart presentations. The PIP validation procedure builds on the CMS PIP Validation Protocol by evaluating quantitative and qualitative data regarding each of the following PIP components:

1. Topic/Rationale
    a. Impacts the maximum proportion of members that is feasible
    b. Potential for meaningful impact on member health, functional status, or satisfaction
    c. Reflects high-volume or high risk-conditions
    d. Supported with PIHP member data (baseline rates; e.g., disease prevalence)
2. Aim
    a. Specifies performance indicators for improvement with corresponding goals
    b. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with rationale (e.g., benchmark)
    c. Objectives align aim and goals with interventions
3. Methodology
    a. Annual performance measures indicated
    b. Specifies numerator and denominator criteria
    c. Procedures indicate data source, hybrid versus administrative, reliability
    d. Sampling method explained for each hybrid measure
4. Barrier analysis, using one or more of the following:
    a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics
    b. Obtain direct member input from focus groups, quality meetings, surveys, and/or care management outreach
    c. Obtain direct provider input from focus groups, quality meetings, surveys, and/or care management outreach
    d. QI process data (e.g., fishbone diagram, process flow diagrams)
5. Robust interventions that are measureable using ITMs
    a. Informed by barrier analysis
    b. Actions that target member, provider, and PIHP
    c. New or enhanced, starting after baseline year
    d. With corresponding monthly or quarterly ITMs to monitor progress of interventions.
6. Results table
    a. Performance Indicator rates, numerators, and denominators
    b. Target rate
7. Discussion
    a. Interpretation of extent to which PIP is successful (e.g., compare final to baseline rates, compare final to target rates, interpret ITM rate trends in support of performance indicator improvement)
8. Next steps
    a. Lessons learned
    b. System-level changes made and/or planned
    c. Next steps for each intervention

The following PIP was active during the ATR review period (July 1, 2019–June 30, 2020): Monitoring Hospitalization Follow-Up Practices.

Monitoring Hospitalization Follow-Up Practices

Aim: By the end of 2021, Magellan Healthcare aims to increase connection and engagement with outpatient behavioral health providers within the first 7 but no later than 30 days for CSoC youth experiencing acute inpatient psychiatric hospitalization. Magellan will monitor indicators for six months to establish a baseline. Results will be evaluated on a monthly and quarterly basis thereafter to monitor progress towards goals, effectiveness of interventions and the identification of new barriers affecting attendance.

Preliminary baseline data was measured from January 1, 2018, to December 31, 2018; final baseline data were measured from January 1, 2019, to June 30, 2019. Interventions began on July 31, 2019. The final measurement period is January 1, 2021, to December 31, 2021. Magellan will submit their final report on May 1, 2022.

Performance Indicators: Two performance indicators (7-Day Follow-Up After Hospitalization for a Mental Illness and 30-Day Follow-Up After Hospitalization for a Mental Illness) were used to measure the success of PIP interventions.

Indicator 1: 7-Day Follow-Up Hospitalization (FUH) Rate.

Data Source: Administrative Claims Data.

Eligible Population

- Product line: Medicaid.
- PIHP: Full eligibility in the CSoC administered by the CSoC Contractor, Magellan Healthcare, Inc.
- Ages: 6 years and older as of the date of discharge.
- Continuous enrollment: Date of discharge through 30 days after discharge.

Exclusion Criteria: Members without an inpatient hospitalization are excluded. There are inpatient and outpatient claim data limitations due to the payment guidance that mandates how members transition care between the CSoC Contractor and PIHPs at referral and discharge; thus, the denominator excludes members with partial eligibility in which Magellan is not responsible for payment of both the inpatient hospital admission and the subsequent outpatient visit claims up to thirty days after inpatient discharge.

Numerator: The number of discharges with a valid FUH service within 1 to 7 days of the acute inpatient discharge. Magellan Health in Louisiana does not have medical claims necessary to identify medical inpatient admissions following a mental illness discharge (these discharges are excluded from the official calculation), nor do we have outpatient services paid by the medical benefit that meet HEDIS FUH Criteria. FUH criteria include:

- A visit (FUH Stand-Alone Visits Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner.
- A visit in a behavioral healthcare setting (FUH Revenue Codes Group 1 Value Set).

Denominator: An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, all discharges on or between January 1 and December 1 of the measurement year will be included.

Indicator 2: 30-Day Follow-Up Hospitalization (FUH) Rate.

Data Source: Administrative claims data.

Eligible Population

- Product line: Medicaid.
- PIHP**:** Full eligibility in the CSoC administered by the CSoC Contractor, Magellan Healthcare, Inc.
- Ages: 6 years and older as of the date of discharge.
- Continuous enrollment: Date of discharge through 30 days after discharge.

Exclusion Criteria: Members without an inpatient hospitalization are excluded. There are inpatient and outpatient claim data limitations due to the payment guidance that mandates how members transition care between the CSoC Contractor and PIHPs at referral and discharge; thus, the denominator excludes members with partial eligibility in which Magellan is not responsible for payment of both the inpatient hospital admission and the subsequent outpatient visit claims up to thirty days after inpatient discharge.

Numerator: The number of discharges with a valid FUH service within 1 to 30 days of the acute inpatient discharge. Magellan Health in Louisiana does not have medical claims necessary to identify medical inpatient admissions following a mental illness discharge (these discharges are excluded from the official calculation) nor do we have outpatient services paid by the medical benefit that meet HEDIS FUH Criteria. FUH criteria include:

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner.
- A visit in a behavioral healthcare setting (FUH Revenue Codes Group 1 Value Set).

Denominator: An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, all discharges on or between January 1 and December 1 of the measurement year will be included.

Interventions: Interventions by date of implementation are presented in **Table 4**.

Table 4: Interventions by Date of Implementation

Date Implemented (MM/YY)	Interventions
08/17–10/19	• Implement weekly inpatient clinical rounds to review youth that will focus on youth require medical, clinical, wraparound and/or medical coordination of care to facilitate discharge planning. Rounds will provide a mechanism to exchange of information between the clinical staff including UM and CM care managers, CSoC coordinators, medical director, clinical director and/or clinical supervisor and PIHP liaison. Topics addressed will be individualized according to the youth's needs and could include: ○ events/behaviors associated with the admission; ○ current mental health status; ○ progress towards IP treatment goals; ○ pharmacological and medical interventions; ○ most current expected discharge date and discharge plans; ○ risk factors to be addressed following discharge; ○ relevant information from previous plans of care, including youth and family strengths and needs, strategies that have been effective and barriers that might impact FUH appointment attendance; and ○ identification of new and/or additional services that require prior authorizations; community supports or resources. • Any follow-up actions are documented in the clinical rounds Access database and are monitored by clinical supervisor. • Implementation of intervention will be tracked through the percent of members that were discussed in clinical rounds while in inpatient hospital LOC.

Date Implemented (MM/YY)	Interventions
05/19	Monitor crisis plan submitted as part of the crisis plan for POC, which is submitted following the crisis CFT that is held within 3 days after the inpatient discharge. Plan should include specific formal and/or natural/informal supports and clearly address the reasons that triggered the hospitalization.
08/19	Trend hospital rates by inpatient facility and WAA to identify aberrant trends. If patterns of low compliance are detected, QI project manager will outreach to provider clinical contact to explore any facility/regional factors that impact FUH appointment attendance. Additional interventions will be updated if new barriers are identified and/or interventions will be revised if previously identified interventions not effective.
01/19	Wraparound coordinators will contact member/guardian within first three working days after discharge to ensure FUH plan in place: verify OP appointments and CFT meeting. Identify any barriers to the FUH plan in place and coordinate with providers/WAA if assistance is needed to reschedule or connect member with services.

UM: utilization management; CM: care management; CSoC: coordinated system of care; PIHP: prepaid inpatient health plan; ;FUH: follow-up after hospitalization for mental illness; LOC: level of care; POC: plan of care; WAA: wraparound agency; QI: quality improvement; OP: outpatient.

Baseline, Goals, and Results: Table 5 reports the baseline, interim and target rates for each performance indicator. Final rates are not reported because the measurement period is outside the reporting period for this ATR (July 1, 2019–June 30, 2020).

Table 5: Baseline, Interim Results, Final Results and Target Rate

Performance Indicator	Baseline Period 1/1/2018–12/31/2018	RP 1 1/1/2019–6/30/2019	RP 2	Final Measurement Period	Final Goal/ Target Rate
Indicator 1: 7-Day Follow-Up Hospitalization (FUH) Rate	Eligible population = 374 Exclusions = 250 Numerator = 199 Denominator= 374 Rate = 53.2%	Eligible population = 196 Exclusions = 114 Numerator = 93 Denominator = 196 Rate = 47.5%	NA	NA	Target Rate: 70%
Indicator 2: 30-Day Follow-Up Hospitalization (FUH) Rate	Eligible population = 374 Exclusions= 250 Numerator = 273 Denominator= 374 Rate = 73.0%	Eligible population 196 Exclusions= 114 Numerator = 136 Denominator = 196 Rate = 69.4%	NA	NA	Target Rate: 90%

RP: remeasurement period.

Strengths and Opportunities for Improvement

Strengths: There were no performance indicators that showed improvement from baseline to final remeasurement of at least 3 percentage points; however, several ITMs did show improvement, most notably:

- The annualized ITM for parent support involvement during inpatient admission did show improvement by almost 10 percentage points, from 27.59% in 2018 to 37.28% in 2019.
- The quarterly ITM for post-discharge crisis care planning showed quarterly improvement during 2019, from 52.58% in quarter 1 to 60.47% in quarter 4.
- The quarterly ITM for wraparound coordinator follow-up calls within 7 days of discharge increased during 2019, from 35.74% in quarter 1 to 42.64% in quarter 4.

Opportunities for Improvement: The following performance indicators represent opportunities for improvement because they did not show improvement from baseline to final remeasurement of at least 3 percentage points:

- Indicator 1: 7-Day Follow-Up Hospitalization After Hospitalization for a Mental Illness (FUH) Rate
- Indicator 2: 30-DayFollow-Up Hospitalization After Hospitalization for a Mental Illness (FUH) Rate

IPRO PIP validation review and LDH's subject matter expert review of the PIP Interim Report submitted on April 20, 2020, also identified the following opportunities for improvement, and shared this feedback with the plan:

- It may be informative to stratify performance indicators by race/ethnicity in order to identify possible racial barriers and develop culturally sensitive interventions.
- There is an opportunity for Magellan to complete a run chart for the family support organization intervention tracking measure.

Overall Credibility of Results: Credibility or results cannot yet be assessed because as the PIP is still in progress during the ATR review period (July 1, 2019–June 30, 2020).

Conclusion: There was no improvement shown in either of the two performance indicators; however, ITMs do support the progress of interventions. Barrier analysis findings should be used to inform modifications to interventions, particularly for those interventions with stagnating or declining ITM rates.

IV. Health Disparities

For this year's technical report, the LA EQRO evaluated MCOs and PIHPs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. PIHPs were asked to respond to the following questions for the period July 1, 2019, to June 30, 2020:

Did the MCE conduct any studies, initiative or interventions to identify and/or reduce differences in health outcomes, health status, or quality of care between the MCE's Medicaid population and other types of health care consumers (e.g. commercial members) or between members in Medicaid subgroups (e.g. race, ethnicity, gender, age, socio-economic status, geography, education, etc.)?

Magellan's response

Magellan Healthcare of Louisiana (Magellan) is the delegated CSoC Contractor for the LDH. Magellan is responsible for coordination and management of specialized Medicaid behavioral health benefits and services as specified by the Louisiana Medicaid State Plan-approved waivers to Medicaid children and youth who meet CSoC eligibility criteria. CSoC membership is composed of youths for whom the standard Managed Care Organization framework has proven unable to address the acuity and/or complexity of their behavioral health needs, which may result in the inability to remain safely in their homes and communities. CSoC is a specialty behavioral health carve-out plan that applies the practice and principles of the evidence-informed wraparound model of care operating under the CMS 1915(c) waiver assurance.

Access to Care

To qualify for enrollment, a youth must be experiencing behavioral problems that significantly interfere with their ability to function at home, at school, and/or in the community. Youth can be referred by many difference sources, including caregivers, teachers, doctors, and counselors. A significant number of referrals to CSoC come from state agencies such as the Department of Children & Family Services (DCFS) and the Office of Juvenile Justice (OJJ). Numerous studies have evidenced disparities in access, use, and quality in behavioral health services among minority populations, individuals of low socioeconomic status, and those residing in rural areas.

Magellan conducts an annual population assessment in order to assess CSoC member demographic characteristics to ensure sufficient and equitable engagement with minority populations that are more likely to experience disparities in health care. There were 4,358 unique Louisiana youths enrolled in CSoC from January 1, 2019 through December 31, 2019. Demographic reports indicate strong penetration of minority populations, including 56.48% (*n* = 2,468) identifying as African American and 71% (*n* = 1,644) who resided in a rural setting. Historical trends in CSoC member demographics have been stable since the program's inception, and there were no notable changes to the composition of age, race, gender, or ethnicity categories observed in 2018 and 2019. When 2020 census data are available, Magellan will conduct a comparative analysis to identify any notable differences in demographics at the national, state, and program level, which may indicate potential underrepresentation in gender, racial, or ethnic group.

Both access to health services and the quality of those services can impact health outcomes. Studies have shown that lack of access or limited access to health services can significantly impact an individual's health status. Barriers to accessing health services can include high costs associated with care, lack of insurance coverage, and lack of availability of services in one's community. In addition, individual behaviors such as substance abuse, diet, and physical activity also play a critical role in health outcomes. For example, maintaining a daily exercise program is associated with reduced symptoms of depression and anxiety. The CSoC program, through the application and implementation of wraparound practices, intrinsically and directly addresses many of the known disparities in health services and individual behavior that are experienced by CSoC enrollees. Specific actions taken to minimize or reduce disparities in CSoC include the following:

- Every youth is provided with a designated wraparound facilitator (WF) that guides the youth and family through the wraparound process upon referral, during enrollment, and at discharge. WFs are responsible for ensuring that all members have ongoing assessments to identify needs, developing and implementing a POC that specifies formal and informal services necessary to address those needs, creating an individualized crisis plan, working to overcome

barriers, revising the plan to address emerging or worsening needs, and developing a transition plan for seamless discharge back to the youth's PIHP.

- All CSoC youth are assessed by a licensed mental health practitioner (LMHP) through the administration of standardized assessment tools, including:
  - the Child and Adolescent Needs and Strengths (CANS) screening for the assessment of co-occurring behavioral health, substances use, physical health needs, and exposure to negative social determinants of health;
  - the Patient Health Questionnaire-9 (PHQ-9) and the Mood and Feelings Questionnaire Short Version (MFQ-SV) for depression screening; and
  - the Adverse Childhood Experiences (ACEs) questionnaire for the identification of trauma.
- Development and implementation of an individualized POC that must include sufficient supports and services to address the member's goals and assessed health needs (e.g., risk behaviors, physical, functional, and behavioral health needs, etc.), specify the amount and frequency of each service, and identify the type of provider to furnish each service including necessary Medicaid services and informal supports. The POC Review Tool is used to identify actionable needs for youth and families and ensure that those needs are met through the services provided. Magellan care managers monitor all member POCs at a minimum of every 180 days to evaluate that the identified strategies and interventions comply with waiver assurances, National Wraparound Initiative (NWI) best practices, principles of wraparound, and LDH and Magellan requirements.
- Magellan provides a written, electronic report for each reviewed plan with ratings and individualized feedback when deficiencies are identified. Individual remediation is required when a plan does not meet established standards, which requires the WF to work with the CFT to revise the POC as needed. The POC is then resubmitted and reviewed by the care manager to ensure standards were met prior to authorizing services.
- Wraparound agencies survey youth and guardians at least monthly to ensure the POC is being implemented in accordance with youth and family needs. If barriers are identified, the wraparound agency provides individual remediation to support the youth and family.
- Magellan's PIHP liaison coordinates with the PIHP when there is a reported issue in accessing needed physical health and pharmacy benefits, such as having difficulty accessing prescribed medications; when a medical condition requires involvement with medically complex/condition case management; or when there are barriers in accessing a medical specialist.

LDH quality improvement strategy (QIS) establishes performance measures to monitor access to care and outcomes. The measures are reported quarterly, allowing administrators and program directors to have a real-time mechanism to monitor results and implement process improvement initiatives as needed. Results reported for April 1, 2020–June 30, 2020, show evidence of strong engagement with formal services needed to support improved outcomes:

- All (100% of) CSoC children are enrolled with a wraparound agency providing intensive care coordination via a single POC.
- Nearly all (98% of) members (*n* = 2,293) enrolled in June 2020 reported they are receiving services in the type, amount, duration, and frequency specified in their POC.
- Of those in CSoC, 88% of youth and families (*n* = 2,594) received a behavioral health outpatient or a home- and community-based service, as evidenced by paid claims as of August 17, 2020.

Health Outcomes

The Quality Improvement (QI) Work Plan sets forth the performance measures and activities used to measure outcomes, assess quality performance, identify opportunities for improvement, initiate targeted quality interventions, and regularly monitor each intervention's effectiveness. A summary of key outcome measures is presented in the following paragraphs. The results demonstrate positive outcomes and demonstrate the effectiveness of the CSoC program in successfully addressing the behavioral health needs of its members.

- **Improvement in Clinical Functioning.** The CANS is utilized to measure clinical improvement for youth discharging from the CSoC program. Improvement is defined as the percentage of members with a decrease of 5 or more points in their global CANS score from initial assessment to discharge assessment. From January to December 2019, 71.8% of CSoC youth demonstrated a CANS global score improvement of 5 or more points from initial assessment to discharge assessment (*n* = 2,303). When examining the results by the two largest racial groups, 73.8% of African American youth (*n* = 1,267) and 71.1% of white youth showed clinical improvement.

- **Social Determinants of Health:** The effectiveness of the CSoC program in countering negative impacts of social determinants of health is monitored by comparing the prevalence rates of actionable need and strengths items at the initial and discharge CANS assessments. An actionable need is defined as a CANS item with a rating of 2 or 3. These ratings indicate that treatment or intervention is required by the youth and/or family. **Figure 1** shows the quantitative change rate between initial and discharge actionable need prevalence in a subset of CANS items used to measure common social determinants of health for calendar years 2018 and 2019. As demonstrated in the figure, the prevalence of actionable needs identified on the CANS was markedly reduced from initial to discharge assessments of Family Stress, School, and Social Resources items. The most significant reduction in actionable needs was seen in Social Resources, which fell by 43.1 percentage points. Areas of need that did not demonstrate notable change were Safety and Residential Stability. As these items relate to a family's socioeconomic status, housing opportunities, and regional crime statistics, there is less opportunity for therapeutic intervention. Instead, strategies can be enacted by the CSoC Child & Family Team (CFT) to increase youth and family strengths that serve as protective factors in social determinants of health.

V. Compliance Monitoring

IPRO conducted the 2020 Compliance Audit on behalf of the LDH. Full compliance audits occur every 3 years, with partial audits occurring within the intervening years. The 2020 annual compliance audit was a partial review of the PIHP's compliance with contractual requirements during the period of May 1, 2019, through April 30, 2020.

The audit included a comprehensive evaluation of Magellan's policies, procedures, files, and other materials corresponding to the following five contractual domains:

1. Member Services
2. Provider Network Requirements
3. Enrollment
4. Grievance and Appeal System
5. Program Integrity

The file review component assessed the PIHP's implementation of policies and its operational compliance with regulations related to complaints and grievances, care management, utilization management, provider credentialing, and communication between the PIHP and member and provider communities.
Specifically for this partial review, file review consisted of the following one area:

1. Appeals

Sample sizes for each file review type are presented in **Table 6**.

Table 6: File Review Sample Size

File Type	Sample Size
Appeals	10

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," "non-compliance," and "not applicable" were used for each element under review. The definition of each of the review determinations is presented in **Table 7**.

Table 7: Review Determination Definitions

Review Determination	Definition
Full	The PIHP is compliant with the standard.
Substantial	The PIHP is compliant with most of the requirements of the standard, but has minor deficiencies.
Minimal	The PIHP is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The PIHP is not in compliance with the standard.
Not applicable	The requirement was not applicable to the PIHP.

PIHP: prepaid inpatient health plan.

The 2020 annual compliance audit consisted of three phases: 1) pre-onsite documentation review, 2) online interviews, and 3) post-online interview report preparation.

Summary of Findings

Table 8 provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Table 8: Audit Results by Audit Domain

Audit Domain	CFR 438 Crosswalk	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Eligibility and Enrollment	No crosswalk	1	1	0	0	0	0	100%
Member Grievances and Appeals	438.210 Coverage and authorization of services	5	0	2	3	0	0	0%
Provider Network Requirements	438.206 Availability of services 438.207 Assurances of adequate capacity and services 438.208 Coordination and continuity of care 438.230 Subcontractural relationships and delegation 438.242 Health information systems	12	11	1	0	0	0	92%
Member Services	438.210 Coverage and authorization of services 438.224 Confidentiality	3	3	0	0	0	0	100%
Quality Management	438.206 Availability of services 438.207 Assurances of adequate capacity and services 438.208 Coordination and continuity of care 438.214 Provider selection 438.236 Practice guidelines 438.330 Quality assessment and performance improvement program	1	1	0	0	0	0	100%
Program Integrity	438.206 Availability of services 438.207 Assurances of adequate capacity and services 438.208 Coordination and continuity of care 438.210 Coverage and authorization of services	9	9	0	0	0	4	100%
Total		**31**	**25**	**3**	**3**	**0**	**4**	**81%**

[1]N/As are not included in the calculation.
N/A: not applicable.

As presented in **Table 8**, 31 elements were reviewed for compliance. Of the 31 elements, 25 were determined to fully meet the regulations, while 3 substantially met the regulations, 3 minimally met the regulations, and 0 were determined to be non-compliant. Four elements were "not applicable." The overall compliance score indicates that 81% of regulations not fully compliant in the prior review have been addressed by Magellan and are now fully compliant.
It is the expectation of LDH that Magellan submits a corrective action plan for new elements determined to be less than fully compliant.

VI. Strengths, Opportunities for Improvement, and Recommendations

This section reports the conclusions drawn as to the quality, timeliness, and access to care provided by Magellan of Louisiana CSoC to Medicaid recipients, based on data and analysis presented in the previous sections of this report (42 CFR 438.364(a)(1)). The PIHP's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided, based on the opportunities for improvement noted.

Strengths

- Monitoring Hospitalization Follow-Up Practices PIP
  - There were no performance indicators that showed improvement from baseline to final remeasurement of at least 3 percentage points; however, several ITMs did show improvement, most notably:
    - The annualized ITM for parent support involvement during inpatient admission did show improvement by almost 10 percentage points, from 27.59% in 2018 to 37.28% in 2019.
    - The quarterly ITM for post-discharge crisis care planning showed quarterly improvement during 2019, from 52.58% in quarter 1 to 60.47% in quarter 4.
    - The quarterly ITM for wraparound coordinator follow-up calls within 7 days of discharge increased, from 35.74% in quarter 1 of 2019 to 42.64% in quarter 4 of 2019.
- Compliance Monitoring
  - Four of the six compliance domains were 100% compliant.

Opportunities for improvement

- **Monitoring Hospitalization Follow-Up Practices PIP:** The following performance indicators represent opportunities for improvement because they did not show improvement from baseline to final remeasurement of at least 3 percentage points:
  - Indicator 1: 7-Day Follow-Up Hospitalization (FUH) Rate
  - Indicator 2: 30-Day Follow-Up Hospitalization (FUH) Rate
- Compliance Monitoring
  - None of the five Member Grievances and Appeals requirements that were not fully compliant in the 2019 compliance review were found to be fully compliant in the 2020 compliance review.

Recommendations

Recommendation: Compliance Monitoring - None of the five Member Grievances and Appeals requirements that were not fully compliant in the 2019 compliance review were found to be fully compliant in the 2020 compliance review. The PIHP should work with providers to meet their federal and state Member Grievances and Appeals requirements.

Magellan's Response to Prior Recommendations (2018–2019 ATR)

Recommendation: Even though POC 06 passed validation with 29 cases meeting the numerator compliance, 1 case failed due to missing documentation (the plan of care). Absence of this document is of some concern, considering the importance of this measure. Magellan should takes steps to ensure that a plan of care is prepared whenever required and that it is retained with the member's case files. A checklist or face sheet accompanying the member's case file documents may serve to ensure completeness.

PIHP's Response: Sheet Data Validation Reviews

To address this recommendation, Magellan implemented a procedure to ensure consistent and ongoing monitoring of wraparound agency (WAA) treatment records for the purpose of verifying the presence of required documentation, which includes the POC, and ensure reliability and validity of data entered into CSoC Spreadsheet, which is used to fulfill reporting of required performance measures in accordance with Louisiana CSoC Scope of Work 12.2.3.2.2. and 12.4.3.4. Procedure is reviewed by the Quality Improvement Committee annually, with last approval recorded on 09/14/2020. WAAs are required to meet 100% compliance for all items reviewed and are must provide individual and system remedial actions to address deficiencies. The procedure and UM 03 Treatment Record Review Report (pp. 15-16) for 07/01/2020 – 09/30/2020 is included to show evidence of implementation of procedure.

Recommendation: The facility monitoring score sheets were quite thorough and required commentary and corrective action when the provider failed to meet standard. However, there were occasions where the final score was not recorded on the score sheet and could not be located. IPRO recommends the final score be appended to the score sheet itself so it can be readily be found.

PIHP's Response: Number and percent of providers initially meeting licensing and training requirements prior to furnishing waiver services (QP1) The recommendations have been reviewed and current score sheets all include the final score.

Recommendations for LDH

According to 42 CFR 438.364(a)(4), this section of the annual external quality review report provides a summary analysis of how the state can target goals and objectives in the Quality Strategy, under § 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

- Louisiana's 2019 Quality Strategy goals address the following areas: access to care to meet enrollee needs, improvement in coordination and transitions of care, and facilitation of patient-centered, whole-person care; promotion of wellness and prevention, improvement of chronic disease management and encouragement for partnering with communities to improve population health and address health disparities; and payment for value and incentives for innovation, while minimizing wasteful spending. Based on results presented in the CSoC Program's EQR findings from performance measure validation and their current PIP, opportunities for improvement for this PIHP are particularly evident in the area of follow-up after hospitalization for mental illness. In addition to the PIHP evaluating the effectiveness of their current interventions in this area, LDH, in collaboration with the EQRO, and partnering with other state agencies such as the Office of Behavioral Health can help CSoC better structure effective initiatives to address the need for improvement in coordination and transition of care.
- With each annual EQR report, the state is encouraged to review the Quality Strategy's goals and objectives in light of the compliance review findings, aggregation and analysis of quality and access/timeliness data; and validation of PIPs and make adjustments and updates to the strategy as needed.

References

[1] State of Louisiana Department of Health. (2018, November). *Louisiana Coordinated System of Care standard operating procedures.* https://ldh.la.gov/assets/csoc/Documents/SOPManual/CSoC_SOP_11-2018-Final.pdf.