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External Quality Review
FINAL Annual Technical Report
Magellan of Louisiana CSoC Program

State of Louisiana Office of Behavioral Health

State Fiscal Year 2021

Review Period: July 1, 2020–June 30, 2021

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I. Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as "the degree to which an MCO, PIHP[1], PAHP[2], or PCCM[3] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 CFR § 438.364 External review results (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality of, timeliness of and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

To comply with *Title 42 CFR Section § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Louisiana Department of Health (LDH) contracted with IPRO, an EQRO, to conduct the state fiscal year (SFY) 2021 EQR activities for Magellan, which furnishes Coordinated System of Care (CSoC) for Louisiana's services in the state. The period under review is SFY 2021 (July 1, 2020–June 30, 2021).

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the four (4) mandatory EQR activities that were conducted. It should be noted that validation of network adequacy and assistance with the quality rating of MCOs were conducted at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. Protocols 1, 2, 3, 4, 5, and 7 require each state to assess their MCPs' information system (IS) capabilities. The regulations at 42 C.F.R. § 438.242 and 457.1233(d) also require the state to ensure that each MCP maintains a health information system that collects, analyzes, integrates, and reports data for areas including, but not limited to, utilization, grievances and appeals, and disenrollment for reasons other than the loss of Medicaid eligibility. As set forth in *Title 42 CFR Section § 438.358 Activities related to external quality review* (b)(1), these activities are:

(i) ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.

[1] prepaid inpatient health plan.
[2] prepaid ambulatory health plan.
[3] primary care case management.

(ii) ***CMS Mandatory Protocol 2:*** **Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determined the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.

(iii) ***CMS Mandatory Protocol 3:*** **Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.

(iv) ***CMS Mandatory Protocol 4:*** **Validation of Network Adequacy** – This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population. (CMS has not published an official protocol for this activity.)

CMS defines *validation* in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

The results of these EQR activities are presented in individual activity sections of this report. Each of the activity sections includes information on:

- data collection and analysis methodologies,
- comparative findings, and
- where applicable, the MCOs' performance strengths and opportunities for improvement.

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2020–2021 EQR activity findings to assess the performance of the CSoC Program in providing quality, timely, and accessible healthcare services to Medicaid members.

The following provides a high-level summary of these findings for the Louisiana CSoC Program.

Strengths Related to Quality, Timeliness and Access

The EQR activities conducted in SFY 2021 demonstrated that LDH and the Magellan share a commitment to improvement in providing high-quality, timely, and accessible care for members. Program strengths included the following:

Performance Improvement Projects

IPRO's validation of the MCOs' 2020 PIPs confirmed the state's compliance with the standards of 42 CFR § 438.330(a)(1). The result of the validation activity determined that the MCOs partially or fully met all validation requirements.

- 5/6/20 – In 2021, Magellan initiated a training program for Wraparound Facilitators (WF) in order to better facilitate family participation and collaborative Plan of Care development.
- 5/6/20 – Family Support Organization (FSO) involvement showed improvement from 2019 to 2020.
- The PIP aligns the aim with robust interventions designed to address barriers, and has begun monitoring the progress of interventions using intervention tracking measures, which also monitor provider interventions.
- The PIP topic is supported by the rationale and member data on follow-up visits after inpatient psychiatric hospitalization.
- The performance indicators are relevant and clearly specified, with supporting procedures to ensure data integrity.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

IPRO developed a tool for review based on CFR 438.206. Magellan demonstrated full compliance in 9 of the 11 domains based on federal and state regulations.

Performance Measures

IPRO's validation of the MCOs' performance measures confirmed the state's compliance with the standards of 42 CFR § 438.330(a)(1). The results of the validation activity determined that the MCO was compliant with the standards of 42 CFR § 438.330(c)(2).

Five measures were selected for validation, and all five measures passed validation at 100%:

1. Follow-Up After Hospitalization for Mental Illness (FUH),
2. Number and percent of initial participants who meet the level of care requirements prior to receipt of services (LOC01),
3. Number and percent of participants whose plan of care was updated when the participant's needs changed (POC05),
4. Improved School Functioning (QM10), and
5. Utilization of Natural Supports (QM13).

Because the measures selected for validation change each year, no year-to-year comparisons could be made for these measures.

Network Adequacy

LDH monitors compliance with regulations using GeoAccess reports submitted by Magellan on a quarterly basis. These reports are validated for compliance, and any areas less than fully compliant must be explained by the MCO and a plan of action to correct deficiencies must be submitted.

In the June 2021 GeoAccess Report, Magellan met GeoAccess standards specified in the state contract for the provider types reviewed for 100% of its Medicaid membership, demonstrating full compliance. LDH has been found to be compliant with monitoring Magellan's network adequacy through the establishment of GeoAccess time and distance standards and the generation of quarterly reports.

Opportunities Related to Quality, Timeliness and Access

Performance Improvement Projects

The following measures related to timeliness and access remain opportunities for improvement:

- The 7-Day Follow-Up Hospitalization Rate declined to 46.32% from 52.59% and did not reach the goal of 52.45%.
- The 30-Day Follow-Up Hospitalization Rate declined to 63.68% from 72.59% and did not reach the target of 73.13%.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

Adequate Capacity and Service

- This requirement is partially addressed in the CSoC unit-Quality Improvement – Clinical Management Program Evaluation. The plan was not fully compliant with the standards of CFR 438.68; findings are enumerated in **Section V** of this report.

Grievances and Appeals

- Magellan indicated that new revised letter templates were created to satisfy recommendations from the prior year's audit, were approved by LDH on March 3, 2020, and put into use after March 4, 2020. Letter

templates prior to this date did not include new revised language. The plan was not fully compliant with the standards of CFR 438.68; findings are enumerated in **Section V** of this report.

- The process for appeals did not always provide the member an opportunity to examine their case file including treatment records, other documents and records considered during the appeals process and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the appeal. The plan was not fully compliant with the standards of CFR 438.68; findings are enumerated in **Section V** of this report.
- The former letter template did not include, as parties to the appeal: The member and his or her representative; or the legal representative of a deceased member's estate. The plan was not fully compliant with the standards of CFR 438.68; findings are enumerated in **Section V** of this report.
- Missing from the documentation is a description of how and under what circumstances providers may file a complaint with the contractor and under what circumstances a provider may file a complaint directly to LDH. The plan was not fully compliant with the standards of CFR 438.68; findings are enumerated in **Section V** of this report.

Performance Measures

Based on IPRO's review of five performance measures, Magellan was compliant with their rate submissions.

Compliance with Medicaid and CHIP Managed Care Regulations

None identified.

Network Adequacy

None identified.

Conclusion

Findings from SFY 2021 EQR activities highlight the MCO's commitment to achieving the goals of the LDH quality strategy. Strengths related to quality of care, timeliness of care, and access to care were observed across all covered populations.

Magellan has demonstrated strengths in the areas of quality, access, and timeliness through full compliance with 9 of 11 domains in the compliance audit, 100% validation of the performance measures reviewed, monitoring hospitalization follow-up practices, and meeting 100% of geographic access standards for all of its Medicaid membership.

Magellan has also demonstrated strengths in health disparities by taking specific actions aimed at reducing disparities, as well as conducting research to assess quality performance, identify opportunities for improvement, initiate targeted quality interventions, and monitor each intervention's effectiveness.

Recommendations for Magellan

Details of recommendations for LDH are presented in **Section II** of this report. Details of recommendations for Magellan are presented in **Section VII** of this report, with a summary of those recommendations provided below.

Adequate Capacity and Service

- The MCO should continue efforts to monitor the interventions put into place in the latter part of 2019. These include continued engagement of Wraparound Agencies in training and technical support for staff implementation of the workbook project to improve quality of services provided by non-licensed individuals and continued monitoring the impact of increased reimbursement rates.

Grievances and Appeals

- The MCO should ensure that new letter templates, which were approved on March 3, 2020, will be used moving forward to meet compliance with this requirement. Nine (9) of the 10 letters reviewed were for cases prior to the new letter template implementation date; as such, their letter templates did not address item 7 of this requirement.
- The MCO should establish and implement review processes to minimize process errors.
- The new letter templates that were approved on March 3, 2020, should address this issue moving forward.
- The prepaid inpatient health plan (PIHP) should include in its policy a description of the circumstances under which a provider may file a complaint with the contractor and the circumstances under which a provider may file a complaint directly to LDH.

II. Louisiana Medicaid Managed Care Program

Managed Care in Louisiana

On February 1, 2012, the LDH transitioned approximately 900,000 Medicaid enrollees from the state's fee-for-service (FFS) program to a managed care program. The rollout occurred in phases based on designated geographic service areas, resulting in a completed statewide rollout on June 1, 2012.

In 2014, a request for proposal (RFP) was issued for full-risk Medicaid managed care contracts, with a start date of February 1, 2015. The RFP provided for an initial 3-year contract term and the option to extend the contracts up to 24 months. Subsequently, the Louisiana Legislature approved a 23-month extension to these contracts, from February 1, 2018, through the contract expiration date of December 31, 2019. In December 2015, LDH integrated specialized behavioral health services into the managed care program in an effort to improve care coordination for enrollees and facilitate provision of whole-person health care. Louisiana also continued to administer the Coordinated System of Care (CSoC), a single Behavioral Health PIHP (managed by Magellan of Louisiana CSoC Program) to help children with behavioral health challenges that are at risk for 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.

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

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

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

Louisiana Medicaid currently serves over 1.7 million enrollees, approximately 37% of the state's population. There are five statewide MCOs: Aetna Better Health (ABH); AmeriHealth Caritas Louisiana (ACLA); Healthy Blue

(HB); Louisiana Healthcare Connections (LHCC); and UnitedHealthcare Community Plan (UHC). In February 2020, the state announced its intent to contract with two dental Prepaid Ambulatory Health Plans (PAHPs) for Medicaid following a state bid process that began in June 2019 when the Department issued a request for proposals. LDH selected DentaQuest USA Insurance Company, Inc. and MCNA Insurance Company d/b/a MCNA Dental Plans as its dental partners, effective January 1, 2021. On June 24, 2021, LDH initiated procurement for its full-risk Medicaid managed care contracts.

Healthy Louisiana covers more than 90% of Louisiana Medicaid members, including more than 800,000 new members since Medicaid expansion took effect in July 2016. In addition to providing benefits as specified in the Medicaid State Plan, state statutes, administrative rules, and Medicaid policy and procedure manuals, these managed care entities (MCEs) also provide case management services and certain value-added Medicaid benefits. Healthy Louisiana statewide enrollment increased by 23.3%, from 1,406,048 in June 2020 to 1,733,148 in June 2021.

Louisiana Medicaid Quality Strategy

Louisiana's Quality Strategy is based on aims, goals, and objectives to promote improvement in health care delivery and outcomes, along with metrics by which progress can be measured. Louisiana's Quality Strategy is aligned with the Institute of Healthcare Improvement (IHI)'s Triple Aim® and the aims and priorities selected by CMS for their national quality strategy. Posted on the LDH website, Louisiana's 2019 Quality Strategy identifies the following three aims:

1. Better Care: Make health care more person-centered, coordinated, and accessible.
2. Healthier People, Healthier Communities: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs; and
3. Smarter Spending: Demonstrate good stewardship of public resources by ensuring high-value, efficient care.

LDH is currently working on an update to the 2019 Quality Strategy. A draft, dated May 2021, was previously posted for public comment on the LDH website.

Responsibility for Quality Monitoring

Within LDH, the Bureau of Health Services Financing (BHSF) is responsible for the day-to-day operations of the MMC program, with support from other LDH program offices including the Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD). The Medicaid Quality Improvement and Innovations Section, in collaboration with these program offices, the Medicaid Chief Medical Officer, and the Medicaid Executive Management Team, are responsible for the development, implementation and evaluation of the Medicaid Managed Care Quality Strategy.

The Louisiana Medicaid Medical Care Advisory Committee (formerly known as the Medicaid Quality Committee) provides consultation on quality improvement activities to promote access and utilization of quality, evidence-based healthcare that is designed to meet the health needs of all Louisiana Medicaid and Children's Health Insurance Program enrollees. Members of the Medicaid Medical Care Advisory Committee and its subcommittees fulfill the role required by federal regulation 42 CFR 431.12. This committee is interdisciplinary and includes representatives who are familiar with quality improvement and the medical needs of Healthy Louisiana enrollees.

Health Disparities

For this year's technical report, the LA EQRO evaluated MCOs 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, and geography. MCOs were asked to respond to the following questions for the period July 1, 2020–June 30, 2021:

Did the MCO conduct any studies, initiatives, or interventions to identify and/or reduce differences in health outcomes, health status, or quality of care between the MCO'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)?

Numerous studies have evidenced disparities in access to, use, and quality of behavioral health services among minority populations, individuals of low socioeconomic status, and those residing in rural areas. Magellan conducts an annual population assessment for each calendar year of 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, 2020, through December 31, 2020. Demographic reports indicate strong penetration in minority populations, including 55% (*n* = 2,468) of CSoC members identifying as African American and 69% (*n* = 2,172) residing in rural settings. 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 2019 and 2020. **Table 10–Table 14** provide a frequency distribution of membership by gender, race, and ethnicity for calendar years 2019 and 2020.

Both access to health services and the quality of those services can impact health outcomes. The CSoC program, through the application and implementation of wraparound practices, intrinsically and directly addresses many of the known disparities in health services experienced by CSoC enrollees. Specific actions taken to address and reduce disparities in CSoC include, but are not limited to:

- 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. Wraparound Facilitators 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 MCO.
- 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. Additionally, the Patient Health Questionnaire-9 (PHQ-9) and the Mood and Feelings Questionnaire Short Version (MFQ-SV) are recommended for depression screening, and the Adverse Childhood Experiences (ACEs) questionnaire is recommended 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 their assessed 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.
- Wraparound Agencies survey youth and guardians at least monthly to ensure the POC is being implemented in accordance with their needs. If barriers are identified, the Wraparound Agency provides individual remediation to support the youth and family.

- Magellan's MCO liaison coordinates with the MCO 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.

The Quality Improvement (QI) Work Plan sets forth the performance measures and activities used to measure outcomes, assesses 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 below. Time periods reflect the most recent reporting period, either quarterly or annual. The results demonstrate positive outcomes and evidence the effectiveness of the CSoC program in successfully addressing the behavioral health needs of its members, including relevant subpopulations.

- **LDH Quality Improvement Strategy (QIS) Performance Measures.** The QIS establishes performance measures to monitor access to care and outcomes. Measures are reported quarterly, allowing administrators and program directors to have a real-time mechanisms to monitor results and implement process improvement initiatives as needed. Results reported for April 1, 2021–June 30, 2021, show evidence of strong engagement with formal services needed to support improved outcomes:
  - 100% of CSoC children are enrolled with a Wraparound Agency providing intensive care coordination in a single plan of care.
  - 94.2% of members reported they are receiving services in the type, amount, duration, and frequency specified on their Plan of Care in June 2021 (n = 2,086).
  - 91.8% of youth and families are connected with natural and informal community supports to strengthen community ties (n = 2,481).
- **Improvement in Clinical Functioning.** Of those discharging from CSoC in 2020, 72.9% of CSoC youth demonstrated a CANS global score improvement of 5 or more points from initial to discharge assessment (n = 1,326). When examining results by our two largest racial groups, clinical improvement was seen in 70.89% of African American youth (n = 726) as compared to 69.57% of White youth (n = 631). A Chi-square test of independence was performed to examine the relationship between the two groups and indicated there was no statistically significant difference, X^2 (1, N = 1,375) = 0.3011, $P < .05$. These findings provide confidence that once enrolled in CSoC, youth and families experience improved clinical functioning regardless of race.
- **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 (risk factors) and strengths items (protective factors) at the initial and discharge CANS assessments for youth discharging in calendar year 2020. An actionable need or strength item is defined as a CANS item with a rating of 2 or 3. These ratings indicate that treatment or intervention is required to address the identified need. **Figure 1** shows the quantitative change rate from initial to discharge assessments for a subset of risk factors: Family Stress, School, and Social Resources items showed marked reduction. The most significant reductions in needs were seen in Family Stress, which fell by 47.0 percentage points and School Functioning, which decreased by 40.4 percentage points. Areas of need that did not show 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 are added to the youth's Plan of Care (POC) to increase youth and family protective factors, or strengths. **Figure 2** shows the quantitative change rate between initial and discharge assessments for youth discharging from CSoC in 2020 for a subset of protective factors. Improvements were seen in all of the protective factors selected, with the greatest improvements observed in Resiliency, which improved by 53.5 percentage points, and Community Life, which improved by 23.84 percentage points.

- **Attendance of Follow-Up Appointment After Inpatient Hospitalization (FUH).** To assess potential disparities in access to care, an analysis using the disproportionate and proportionate index was completed to examine attendance of a follow-up appointment after discharge from an inpatient psychiatric hospitalization (FUH) within 7 days and 30 days for youth from January 1, 2020, to December 31, 2020. According to Bensimon and Malcolm-Piqueux, proportionate index (PI) values equal to or less than 0.85 are valid and reliable benchmarks to identify instances of disproportionate impact, which translates to a disproportionate index of greater than 117%.[4] In **Table 14**, the PI and disproportionate indexes were calculated for FUH rates of relevant subpopulations including gender, race, ethnicity, and primary language. No instances of disproportionate impact were identified.

IPRO's Assessment of the Louisiana Medicaid Quality Strategy

Evaluation Methodology

To evaluate Louisiana's 2019 Medicaid Managed Care Quality Strategy, a review of federal regulations was initially conducted to clearly define the requirements of the Quality Strategy and guide the evaluation methodology.

First, IPRO evaluated the core Healthy Louisiana performance results. This evaluation consisted of data analysis of measures identified in the Quality Strategy from the Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Agency for Healthcare Research and Quality (AHRQ)'s Preventive Quality Indicators, Louisiana vital records, and CMS-developed measures. This analysis included comparisons of Louisiana HEDIS performance to national benchmarks using the Medicaid National Committee for Quality Assurance (NCQA) *Quality Compass*®.

Second, IPRO evaluated Louisiana Medicaid's Quality Monitoring activities. This evaluation consisted of a review of Louisiana Department of Health monitoring reports regarding enrollment, network adequacy, quality dashboard, program transparency, medical loss ratio (MLR), and diabetes and obesity reviews. LDH's approach to addressing health disparities and the use of sanctions were also reviewed. Further evaluation of the Quality Strategy consisted of a review of external quality review (EQR) report documents, including performance measure results, compliance review results, access and availability survey findings, behavioral health member satisfaction, and the Annual EQR Technical Reports.

Third, IPRO evaluated State-MCO-EQRO communications by reviewing online data sources. In addition to the LDH and external quality review monitoring reports, other website examples of data transparency such as MCO executed contracts, Medical Care Advisory Committee meeting reports and Informational Bulletins were reviewed.

Fourth, IPRO evaluated Louisiana Medicaid's strategies and interventions to promote quality improvement by reviewing MCO Performance Improvement Project reports, MCO withhold of capitation payments to increase the use of Value-Based Payment (VBP) and improve health outcomes, and the Louisiana Health Information Technology Roadmap.

Finally, based on key findings, IPRO prepared a summative analysis of program strengths, opportunities for improvement, and recommendations.

[4] Harris, B. (2015). *2015-16 student equity plan template.* California Community College Chancellor's Office. Retrieved from https://www.lavc.edu/Equity-Diversity-and-Inclusion/document-library/misc/Student_Equity_Plan_Aug2015_Final-(1).aspx .

Strengths

- Louisiana's Medicaid quality strategy aligns with IHI's Triple Aim and with the following priorities of the national Medicaid quality strategy developed by CMS:
  - **Better Care**: Make healthcare more person-centered, coordinated, and accessible.
  - **Healthier People, Healthier Communities**: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.
  - **Smarter Spending:** Demonstrate good stewardship of public resources by ensuring high-value, efficient care.
- LDH conducted a robust set of monitoring activities tracking enrollment, network adequacy, quality of care, member satisfaction, program transparency, medical loss ratio, claims, and diabetes and obesity.
- In compliance with federal regulations, the EQRO prepared federally required MCO Annual Technical Reports. Results for each MCO and a state summary are posted on the LDH website.
- The 2020 annual compliance audit was a partial audit of compliance with federal and state contractual requirements during the period of May 1, 2019–April 30, 2020. Overall results indicated a good level of full compliance. Of those elements that were not 100% during the full review, 81% of total elements reviewed were full compliance.
- LDH has shown its commitment to ensuring that improvements in health outcomes lead to equitable improvements in all groups as it continues to integrate procedures for identifying, evaluating, and reducing health disparities throughout the Healthy Louisiana program.
- There is effective communication between the state, MCOs, and the EQRO as evidenced by regularly scheduled meetings and conference calls for EQR activities. LDH commendably communicates with the MCOs, enrollees and the public through a well-designed and informative internet website.
- There is a structured and standardized approach in place for conducting and validating PIPs. Louisiana's statewide collaborative PIP model offers an opportunity for shared learning and an avenue to address the same message to all MMC providers and members. Individual MCO conference calls with the EQRO, quarterly update reports and monthly or quarterly Collaborative PIP meetings provide valuable insight on PIP progress, and through the use of intervention tracking measures can help quantify opportunities for improvement.
- Healthy Louisiana has successfully integrated quality as a fundamental aspect of the managed care program by introducing an MCO withhold of capitation payment program to improve health outcomes and increase the use of VBP.

Opportunities for Improvement

The Member Grievances and Appeals and Provider Network Requirements areas of the Magellan compliance review were the only domains that were less than 100% fully compliant with CFR 438.340 and the state contract.

Recommendations to LDH

Overall, LDH is successfully implementing the 2019 Quality Strategy, which met minimum CMS standards, but it is recommended that LDH, in collaboration with the EQRO and Magellan, address the above listed opportunities for improvement, as well as the following:

- Because the quality strategy focuses on physical health metrics, LDH should update the Quality Strategy to enhance behavioral health metrics that the state will use to monitor its progress towards meeting established goals.

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO. IPRO's validation of the MCOs' 2020/2021 PIPs confirmed the state's compliance with the standards of 42 CFR § 438.330(a)(1). The result of the validation activity determined that the MCOs partially or fully met all validation requirements.

Section 12.5 of the Magellan contract requires the MCO to perform a minimum of one LDH-approved PIP for the term of the contract. LDH may require up to two additional PIPs for a maximum of three PIPs.

Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and
- Quality of care;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

PIPs engage MCO care and quality managers, providers, and members as a team with the common goal of improving patient care. The MCO 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 re-chart the PIP course. Positive ITM trends are an indication of robust interventions.

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; and
    d. Is supported with MCO 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); and
    c. Objectives align aim and goals with interventions.
3. Methodology
    a. Annual PMs indicated;
    b. Specifies numerator and denominator criteria;
    c. Procedures indicate data source, hybrid versus administrative, reliability; and
    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 PMs 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; and/or
d. Quality improvement (QI) process data (e.g., fishbone diagram, process flow diagrams).

5. Robust interventions that are measurable using ITMs
   a. Informed by barrier analysis;
   b. Actions that target member, provider, and MCO;
   c. New or enhanced, starting after baseline year; and
   d. With corresponding monthly or quarterly ITMs to monitor progress of interventions.
6. Results table
   a. Performance Indicator rates, numerators, and denominators; and
   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; and
   c. Next steps for each intervention.

Technical Methods of Data Collection and Analysis

IPRO collects performance indicator data and ITM data reported by the plans in annual PIP reports, quarterly PIP reports, and monthly Plan-Do-Study-Act (PDSA) run chart presentations.

IPRO's validation process begins at the PIP proposal phase and continues through the life of the PIP. During the conduct of the PIPs, IPRO provides technical assistance to each MCP. The technical assistance includes feedback.

CMS's Protocol 1. Validation of Performance Improvement Projects was used as the framework to assess the quality of each PIP, as well as to score the compliance of each PIP with both federal and state requirements. IPRO's assessment involves the following 10 elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCP's enrollment;
2. Review of the study question(s) for clarity of statement;
3. Review of the identified study population to ensure it is representative of the MCP's enrollment and generalizable to the MCP's total population;
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the PIP;
5. Review of sampling methods (if sampling used) for validity and proper technique;
6. Review of the data collection procedures to ensure complete and accurate data were collected;
7. Review of the data analysis and interpretation of study results;
8. Assessment of the improvement strategies for appropriateness;
9. Assessment of the likelihood that reported improvement is "real" improvement; and
10. Assessment of whether the MCP achieved sustained improvement.

Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. IPRO's assessment of indicator performance was based on the following four categories:

- Target met (or exceeded), and performance improvement demonstrated.
- Target not met, but performance improvement demonstrated.
- Target not met, and performance decline demonstrated.
- Unable to evaluate performance at this time.

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline and interim), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

IPRO received copies of each of Magellan's Performance Improvement Project reports. The reports included the project topic and rationale (including baseline and benchmark data), objectives, description of the methodology and interventions, results and major conclusions of the project, and next steps.

Conclusions and Comparative Findings

Upon final reporting, a determination was made as to the overall credibility of the results of each PIP, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility was at risk for the PIP results.
- The validation findings generally indicate that the credibility for the PIP results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk are enumerated.

Table 1 summarizes the PIP that was active during the ATR review period (July 1, 2020–June 30, 2021). Final PIP results were not due during the ATR review period and were not due to be validated.

Table 1: Magellan PIP Summary, 2020–2021

Magellan PIP Summaries
PIP 1: Monitoring Hospitalization Follow-Up Practices Validation Summary: PIP will be validated upon final report submission.
Aim By the end of 2021, Magellan endeavors to increase CSoC youth attendance to follow-up appointments within 7-30 days of discharge from an acute inpatient psychiatric hospitalization. To achieve this, Magellan will execute connection and engagement with outpatient behavioral health providers within seven but no more than 30 days. The goal of this process is to increase attendance to follow-up care appointments by 17 percentage points from the baseline measure. **Interventions during the ATR period** • Wraparound Coordinator follow-up calls to member/guardian within seven days of discharge • POC Crisis Plan Reviewed/Updated post hospitalization • FSO engagement with caregiver/guardian during hospitalization • FSO engagement with youth and caregiver/guardian within 7 days of hospital discharge

Magellan PIP Summaries
Performance Improvement Summary *Strengths:* • 5/6/20 – In 2021, Magellan initiated a training program for Wraparound Facilitators in order to better facilitate family participation and collaborative Plan of Care development. • 5/6/20 – Family Support Organization involvement showed improvement from 2019 to 2020. • The PIP aligns the aim with robust interventions designed to address barriers, and has begun monitoring the progress of interventions using intervention tracking measures. • ITMs also monitor provider interventions. • The PIP topic is supported by the rationale and member data on follow-up visits after inpatient psychiatric hospitalization. • The performance indicators are relevant and clearly specified, with supporting procedures to ensure data integrity. *Opportunities for Improvement:* None identified.

Table 2 shows all the interventions that have been implemented for this PIP.

Table 2: MCO PIP Interventions (2019-2021) – Monitoring Hospitalization Follow-Up Practices

MCO Interventions	
Magellan	
Date Implemented (MM/YY)	Interventions
07/19	• Disseminate a daily inpatient hospital report to the Family Support Organization, the statewide provider organization that provides PST services to CSoC members. The report includes only members that have PST authorizations and includes data on members with an open or closed inpatient authorization within ± 30 days of the report run date. The report notifies the FSO of a member's inpatient admission within one business day of Magellan's knowledge to facilitate swift engagement with WF and/or guardian to provide additional support while youth is hospitalized.
10/19	• Implementation of the intervention will be monitored by monthly report for PST claims processed during the youth hospitalization to monitor engagement of the Parent Support Specialist.
10/19	• Initiate Inpatient Hospital monthly email notifications for FSO to reinforce training objectives.
01/20	• Implementation of revised monthly FSO PST claims report that reflects youths hospitalized with existing PST authorization.
02/21	• Develop a comprehensive training on the Roles and Responsibilities of WF during a youth's inpatient hospitalization to address the objectives below. Attendance of trainings will be mandatory for clinical directors and supervisors. Completion of trainings will be monitored through provider attestations. o Increase WF understanding of how to engage with inpatient hospitals during critical points in treatment, including at admission, during treatment, and at discharge. Areas to be addressed include: scheduling a family session, purpose of the family session, identification of events/behaviors triggering inpatient hospitalization, preparation of residence for youth's return – including safety precautions, revision of crisis plan, development of viable discharge plans, identification of barriers to FUH appointment attendance, requesting prior authorizations for medications, etc. o Increase WF understanding of Magellan's role and responsibilities at critical points in treatment, including daily notification to WAA of any known admissions, expected discharge dates, and date and time of next scheduled family session and procedures conducted by CSoC

MCO Interventions	
03/21	coordinators following inpatient discharge (e.g., telephonic contact with member with 72 hours of discharge, assisting with barriers to attending FUH appointments, etc.). ○ Implement Family IPP Resources document, WF IPP Checklist, and the FSO IPP Checklist. • Initiate Inpatient Hospital monthly email notifications for WF to reinforce training objectives.
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.
02/21 03/21	Hold training during QI/QM call to review methodology for the FUH report and clarify thresholds and expectations related to FUH. WAA and FSO training to implement Family IPP Resources document, WF IPP Checklist, and the FSO IPP Checklist. The training will highlight education of FUH importance and FUH rates indictive of engagement success with families.

MCO: managed care organization; PIP: performance improvement project; CSoC: Coordinated System of Care; FSO: Family Support Organization; WF: Wraparound Facilitator; WAA: Wraparound Agency; FUH: Follow-Up (After) Hospitalization; OP: outpatient.

Table 3 shows PIP validation results for each review element of the PIP. IPRO's assessment of indicator performance was based on the following four categories:

- Target met (or exceeded), and performance improvement demonstrated.
- Target not met, but performance improvement demonstrated.
- Target not met, and performance decline demonstrated.
- Unable to evaluate performance at this time (results are not available yet).

Table 3: PIP Validation Results for PIP Elements

Validation Element	PIP 1
Magellan	Monitoring Hospitalization Follow-Up Practices
1. Topic/ Rationale	
a. Impacts the maximum proportion of members that is feasible	Met
b. Potential for meaningful impact on member health, functional status or satisfaction	Met
c. Reflects high-volume or high risk-conditions	Met
d. Supported with MCO member data (baseline rates), e.g., disease prevalence	Met
2. Aim	
a. Specifies Performance Indicators for improvement with corresponding goals	Met
b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	Not Met
c. Objectives align aim and goals with interventions	Met
3. Methodology	
a. Annual Performance Measures indicated	Met
b. Specifies numerator and denominator criteria	Met
c. Procedures indicate methods for data collection and analysis	Met
d. Sampling method explained for each hybrid measure	Not Applicable
4. Barrier Analysis, using one or more of following:	
a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	Partially Met
b. Member feedback	Met
c. Provider feedback	Met
d. QI Process data ("5 Why's", fishbone diagram)	Partially Met

Validation Element	PIP 1
5. Robust Interventions that are Measurable using Intervention Tracking Measures	
a. Informed by barrier analysis	Partially Met
b. Actions that target member, provider and MCO	Met
c. New or enhanced, starting after baseline year	Met
d. With corresponding monthly or quarterly intervention tracking (process) measures, i.e., numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	Partially Met
6. Results Table (Completed for Baseline, Interim and Final Re-Measurement Years)	
a. Table shows Performance Indicator rates, numerators and denominators	Met
b. Table shows target rates and rationale (e.g., next highest Quality Compass percentile)	Partially Met

PIP: performance improvement project; MCO: managed care organization.

2b. IPRO Review of REVISED 2nd Interim Report on 6/9/21: Indicator #1 baseline rate = 52.59% and the target rate is lower, at 52.45%. Indicator #3 baseline rate = 72.59%, and the target rate is the same when rounded, at 73.13%. The target rate for each indicator should be 10 percentage points higher than the baseline rate over a 3-year period.

4a. IPRO Review of REVISED 2nd Interim Report on 6/9/21: Please check all of your rate calculations in Microsoft® Excel, as calculation errors were observed. For example, in the row for black or African American members, the correct calculation for 174/354 = 49.15%, not 45.79% as reported in your worksheet table. Tables 8 and 9 should document measurement periods and the statistical test that resulted in the reported *P* value. Of note, in the Discussion section, the plan indicated that the Chi-square test was used; however, this test is only a measure of association and does not inform interpretations of which rates are statistically different when compared to one another, particularly when there are three categories (e.g., "no," "≤ 60 days," and "≥ 60 days"). Also check your categories to make sure that they do not overlap (e.g., "≥ 30 days" and "≤ 31 days"). Rather than report the Chi-square statistic, the Plan is advised to calculate 95% confidence intervals for each rate, then interpret non-overlapping 95% CIs as statistically different, and report only statistically significant findings. Then use statistically significant findings to flag the need for drill-down analysis, conduct drill-down analysis to identify barriers/root causes, and use drill-down analysis findings to inform modifications to interventions. This should be conducted on an ongoing basis, consistent with continuous quality improvement (CQI) and the Plan-Do-Study-Act approach to CQI.

4d. IPRO Review of REVISED 2nd Interim Report on 6/9/21: Rather than plot monthly ITM #6 rates on a run chart, as requested in the 5/6/21 review, the plan graphed performance indicator rates on a run chart; however, this does not provide concurrent information to answer the question, "Is the intervention for Wraparound Coordinator follow-up calls to member/guardian within seven days of discharge- and with successful contact- working?" The plan is advised to plot ITM #6 monthly and, in response to stagnating or declining rates, conduct a drill-down analysis to identify root causes/barriers, and use drill-down analysis findings to modify this intervention in real time. The plan should plot ITM #6 on a monthly run chart, as well as the new ITMs for the tailored and targeted intervention to be developed for Region #2, based upon a barrier analysis for that region.

5a. IPRO Review of REVISED 2nd Interim Report on 6/9/21: The plan did conduct the recommended analysis of disproportionate representation and did identify Region 2 as a susceptible subpopulation; however, there was no intervention tailored and targeted to this subpopulation. The plan is advised to tailor and target an intervention to eligible enrollees and providers in Region 2 with a corresponding member ITM. To inform a meaningful intervention, it will be necessary to conduct a drill-down analysis of the barriers/root causes

attributable to Region 2, and direct member and provider feedback is recommended. The plan is also advised to plot the new ITMs monthly on a run chart, with monthly evaluation to determine whether the ITM is improving, stagnating, or declining. If the new ITM is stagnating or declining, conduct a drill-down analysis to determine root causes/barriers, and modify the intervention for ongoing improvement.

5d. IPRO Review of REVISED 2nd Interim Report on 6/9/21: Y2Q3 ITM 6 rate for Wraparound Coordinator follow-up calls to member/guardian within 7 days of discharge decreased from 42.64% in Y1Q4 (55/129) to 28.17% (40/142) in Y2Q2, then increased to 100% (76/76) in Y2 Q3. This would appear to be an improvement; however, clarification is merited regarding who was excluded from the Y2 Q3 denominator, as 76 is approximately half the preceding quarter denominator of 142. An ITM for a tailored and targeted intervention for Region 2 is merited.

6b. IPRO Review of REVISED 2nd Interim Report on 6/9/21: Target rates with rationale are indicated; however, these targets are inappropriate for the following reasons. Indicator #1 baseline rate = 52.59% and the target rate is lower, at 52.45%. Indicator #3 baseline rate = 72.59%, and the target rate is the same when rounded, at 73.13%. The target rate for each indicator should be 10 percentage points higher than the baseline rate over a 3-year period.

Table 4 shows interim performance for the indicators for the PIP. IPRO's assessment of indicator performance was based on the following four categories:

- Target met (or exceeded), and performance improvement demonstrated.
- Target not met, but performance improvement demonstrated.
- Target not met, and performance decline demonstrated.
- Unable to evaluate performance at this time.

Table 4: Assessment of Magellan PIP Indicator Performance

MCO	Indicator #	Indicator Description	Assessment of Performance, Baseline to Interim	Assessment of Performance, Baseline to Final
		Monitoring Hospitalization Follow-Up Practices		
Magellan	1	7-Day Follow-Up Hospitalization Rate Baseline rate: 52.59% Interim rate: 46.32% Target rate: 52.45%	Target not met, and performance decline demonstrated.	Unable to evaluate performance at this time.
	2	30-Day Follow-Up Hospitalization Rate Baseline rate: 72.59% Interim rate: 63.68% Target rate: 73.13%	Target not met, and performance decline demonstrated.	Unable to evaluate performance at this time.

PIP: performance improvement project; MCO: managed care organization.

IV. Validation of Performance Measures

Objectives

Louisiana Department of Health's Office of Behavioral Health (OBH) selects a set of performance measures to evaluate the quality of care delivered by Magellan for their CSoC members. For CY 2021, OBH required Magellan to report a total of 49 PMs.

Title 42 CFR 438.358(a)(1) and 438.358(b)(ii) require that these performance measures be validated by the state, its agent, or an EQRO. IPRO conducted this activity on behalf of LDH for CY 2021.

Technical Methods of Data Collection and Analysis

IPRO, in consultation with the OBH, selected five performance measures reported by Magellan. Fourth quarter 2020 data were collected for validation. The measures selected for validation are representative of the care plan oversight and service monitoring required by Magellan to help ensure the success of the CSoC program.

The five measures selected for validation were:

- Follow-Up After Hospitalization for Mental Illness (FUH),
- Number and percent of initial participants who meet the level of care requirements prior to receipt of services (LOC01),
- Number and percent of participants whose plan of care was updated when the participant's needs changed (POC05),
- Improved School Functioning (QM10), and
- Utilization of Natural Supports (QM13).

Description of Data Obtained

For each measure selected for validation, IPRO requested the universes of cases that met numerator compliance for the 10/1/20 – 12/31/20 review period, which was the most recent period of data available. Magellan uploaded the universes for each of the five measures to IPRO's secure File Transfer Protocol (FTP) site in March 2021. From the universes, IPRO randomly sampled 30 cases for validation.

Once the sample was selected, IPRO requested that Magellan provide the documentation that supported numerator compliance for each case in the measure. IPRO analysts reviewed each file to determine the accuracy of Magellan's results. IPRO reviewed the documentation in accordance with the measure specification and determined whether the case "passed" validation (i.e., the documentation met the specifications of the measure).

Conclusions and Findings

A review of data by IPRO determined that the rates reported by Magellan were calculated in accordance with the defined specifications and that there were no data collection or reporting issues identified. All five measures reviewed passed IPRO validation at 100%.

As part of the 2019/2020 compliance review, IPRO found that Magellan met the requirement of maintaining a management information system (MIS) that collects, analyzes, integrates and reports data that comply with LDH and federal reporting requirements. The system provides information on utilization, grievances and appeals.

Table 5 shows rates for the five measures validated.

Table 5: Magellan Performance Measures

Measure	Type of Measure	Reported Rate	Reporting Period
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day	HEDIS	40.19%	1/1/2020–10/31/2020
30-Day	HEDIS	58.20%	1/1/2020–10/31/2020
Number and percent of initial participants who meet the level of care requirements prior to receipt of services (LOC01)	LDH	100%	7/1/2020–6/30/21
Number and percent of participants whose plan of care was updated when the participant's needs changed (POC05)	LDH	100%	7/1/2020–6/30/21
Improved School Functioning (QM10)	LDH	71.09%	10/1/2020–12/31/2020
Utilization of Natural Supports (QM13)	LDH	90.7%	10/1/2020–12/31/2020

HEDIS: Healthcare Effectiveness Data and Information Set; LDH: Louisiana Department of Health.

V. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

According to 42 CFR §438.358, a review must be conducted within the previous 3-year period that determines a plan's adherence to standards established by the state related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards, as well as applicable elements of LDH's MMC provider agreement with the plans. The most recent comprehensive review of Magellan covered the SFY 2020 review period of May 1, 2019–April 30, 2020. In follow-up to the SFY 2020 Comprehensive Administrative Review (CAP), LDH required CAPs from Magellan for program areas with deficiencies.

Technical Methods of Data Collection and Analysis

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCOs. For each set of standards reviewed, IPRO prepared standard-specific review tools with standard-specific elements (i.e., sub-standards). The tools include the following:

- Statement of federal regulation and related federal regulations,
- Statement of state regulations,
- Statement of state and MCO contract requirement(s),
- Suggested evidence,
- Reviewer determination,
- Prior results,
- Descriptive reviewer findings and comments related to findings, and
- MCO response and action plan.

IPRO's compliance audit included a comprehensive evaluation of policies, procedures, files and other materials corresponding to the following 11 domains:

1. Availability of services,
2. Assurances of adequate capacity and services,
3. Coordination and continuity of care,
4. Coverage and authorization of services,
5. Provider selection,
6. Confidentiality,
7. Grievance and appeal systems,
8. Subcontractual relationships and delegation,
9. Practice guidelines,
10. Health information systems, and
11. QAPI.

During these audits, determinations of full compliance, substantial compliance, minimal compliance, and non-compliance were used for each element under review. Definitions for these review determinations are presented below:

Full – The MCO has met or exceeded the standard.
Substantial – The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal – The MCO has met some of the requirements of the standard but has significant deficiencies that require corrective action.

Non-Compliance – The MCO has not met the standard.
Not Applicable – The standard is not subject to review.

Description of Data Obtained

IPRO conducted the 2020 compliance audits on behalf of the LDH in 2019 and 2020. Full compliance audits occur every 3 years, with partial audits occurring within the intervening years. The last full compliance audit occurred in 2019. The 2020 annual compliance audit was a partial review of each MCO's compliance with contractual requirements during the period of May 01, 2019–April 30, 2020.

During this review period, Magellan was the only behavioral health PAHP. The last compliance audit for Louisiana took place in 2020 and the next comprehensive audit is anticipated to take place in late 2022.

For this audit, compliance determinations of "full," "substantial," "minimal," "non-compliance," and "not applicable" were used for each element under review. CFR standards for the compliance review and the results of that review for Magellan are presented in **Table 6**.

Table 6: CFR Standards for Compliance Review

CFR Standard Name	CFR Citation	Magellan
Overall compliance score:		
Availability of services	438.206	Full
Assurances of adequate capacity and services	438.207, 438.680	Substantial
Coordination and continuity of care	438.208	Full
Coverage and authorization of services	438.114, 438.404, 438.210	Full
Provider selection	438.214	Full
Confidentiality	438.224, 438.56, 438.100, 438.10	Full
Grievance and appeal systems	438.228, 438.402, 438.406, 438.408, 438.424, 438.410, 438.420	Substantial
Subcontractual relationships and delegation	438.230	Full
Practice guidelines	438.236	Full
Health information systems	438.242	N/A
QAPI	438.330, 438.240, 438.242	Full

CFR: Code of Federal Regulations; MCO: managed care organization; N/A: not applicable; QAPI: quality assurance and performance improvement.

Conclusions and Findings

Magellan demonstrated full compliance in 9 of the 11 domains. The following details findings of CFR standards that were less than full.

Magellan

Adequate Capacity and Service

- Finding: This requirement is partially addressed in the CSoC unit-Quality Improvement – Clinical Management Program Evaluation (page 174). Barriers identified, interventions, and recommendations for 2020 were clearly laid out. A major intervention was the increase in reimbursement rates for LMHPs, prescribers, and Short-Term Respite providers, which went into effect in July 2019.
- Recommendation: The MCO should continue efforts to monitor the interventions put into place in the latter part of 2019. These include continued engagement of Wraparound Agencies in training and technical

support for staff implementation of the workbook project to improve quality of services provided by non-licensed individuals and continued monitoring of the impact of increased reimbursement rates.

Grievances and Appeals

- Finding: Magellan indicated that new revised letter templates were created to satisfy recommendations from the prior year's audit, were approved by LDH on March 3, 2020, and put into use after March 4, 2020. Letter templates prior to this date did not include new revised language. One (1) out of 10 denial notification letters fully met the requirement. Nine (9) out of 10 clinical denial notification letters satisfied 7 of the 8 requirements because letters were sent to members prior to the revised letter format date of implementation and did not include item number 7 of the regulatory requirement on the letters.
- Recommendation: The MCO should ensure that new letter templates, which were approved on March 3, 2020, will be used moving forward to meet compliance with this requirement. Nine (9) of the 10 letters reviewed were for cases prior to the new letter template implementation date; as such, their letter templates did not address item 7 of this requirement.
- Finding: The process for appeals did not always provide the member an opportunity to examine their case file including treatment records, other documents and records considered during the appeals process and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the appeal. Nine (9) out of 10 appeals files met compliance with the requirement. One (1) out of 10 appeal letters did not meet compliance, and the plan acknowledges this was due to a copy and paste error from a case manager.
- Recommendation: The MCO should implement review processes to minimize process errors.
- Finding: The former letter template did not include, as parties to the appeal: The member and his or her representative; or the legal representative of a deceased member's estate. One (1) of the 10 appeals files met compliance and 9 out of the 10 appeals did not meet compliance because they used older letter templates.
- Recommendation: The new letter templates that were approved on March 3, 2020, should address this issue moving forward. The MCO should ensure the new template is used moving forward.
- Finding: Missing from the documentation is a description of how and under what circumstances providers may file a complaint with the contractor and under what circumstances a provider may file a complaint directly to LDH.
- Recommendation: The PIHP should include in the policy a description of the circumstances under which a provider may file a complaint with the contractor and the circumstances under which a provider may file a complaint directly to LDH.

VI. Validation of Network Adequacy

Objectives

In the absence of a CMS protocol for 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv), IPRO assessed MCO compliance with the standards of 42 CFR § 438.358 Network adequacy standards and Section 6.3.1 of the state's Medicaid CSoC Services Contract.

Per Section 6.3.1.1, the Contractor shall ensure access to healthcare services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care, facility wait list) in accordance with the provision of services under this contract and in accordance with 42 CFR §438.206(c). The Contractor shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional personnel for the provision of services, including all specialized behavioral health emergency services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

1. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in rural parishes shall not exceed thirty (30) miles or sixty (60) minutes, whichever is less, for one hundred percent (100%) of members.
2. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in urban parishes shall not exceed fifteen (15) miles or thirty (30) minutes, whichever is less, for one hundred percent (100%) of members.
3. Travel distance to specialized behavioral health outpatient non-MD services (excluding behavioral health specialists) shall not exceed sixty (60) miles or ninety (90) minutes, whichever is less, for urban members and ninety (90) miles or one hundred and twenty (120) minutes, whichever is less, for rural members. Maximum time for appointment shall not exceed appointment availability requirements for specialized behavioral health emergent, urgent and routine care.

Technical Methods of Data Collection and Analysis

Magellan monitors its provider network for accessibility and network adequacy using the GeoAccess software program from Quest Analytics. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes. IPRO's evaluation included a comparison of Magellan's access data to state standards for appointment availability and time and distance.

Description of Data Obtained

IPRO's evaluation was performed using network data provided by LDH that was submitted by Magellan in the Specialized Behavioral Health Network Providers Report for the time period 4/1/2021–6/30/21. IPRO obtained the GeoAccess report from LDH for the evaluation included in this technical report.

Conclusions and Comparative Findings

The state's standard is to have 100% of Magellan's network of providers meet the established distance requirements. **Table 7** shows that in June 2021, Magellan met GeoAccess standards for the provider types reviewed for 100% of its Medicaid membership.

Table 7: GeoAccess Provider Network Accessibility

Specialty	Region	Standard	Magellan
BH Specialists	Urban	1 in 15 Miles	100.0%
	Rural	1 in 30 Miles	100.0%
Outpatient Service	Urban	1 in 15 Miles	100.0%
	Rural	1 in 30 Miles	100.0%
Prescribers	Urban	1 in 15 Miles	100.0%
	Rural	1 in 30 Miles	100.0%
Psychiatrists	Urban	1 in 15 Miles	100.0%
	Rural	1 in 30 Miles	100.0%

BH: behavioral health.

VII. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 8** displays Magellan's responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

Magellan Response to Previous EQR Recommendations

Magellan's responses to previous EQR recommendations are presented in **Table 8**.

Table 8: Magellan Response to Previous EQR Recommendations

Recommendation for Magellan	Magellan Responses/Actions Taken	IPRO Assessment of MCO Response[1]
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.	1. What has the MCO done/planned to address each recommendation? Quality control procedures were implemented to ensure integrity of the UM letter templates is maintained. Interventions completed included revision of quality assurance procedures and letter templates and staff trainings. 2. When and how was this accomplished? For future actions, when and how will they be accomplished? All interventions were completed by 10/30/2020. 3. What is the expected outcome of the actions that were taken or will be taken? Intervention goal is to achieve and maintain 100% compliance with all grievance and appeals requirements. 4. What is the MCO's process for monitoring the actions to determine their effectiveness? Magellan conducts reviews of 100% of all appeal files using a standardized audit tool to measure effectiveness of the interventions. Since implementation, Magellan has achieved 100% compliance with this requirement for all complete appeals processed from November 2020 to November 2021 (n = 70). 5. If a recommendation in the 2021 technical report was repeated from the prior year, please indicate if actions taken as a response to the prior recommendation are still current and describe any new initiatives that have been implemented and/or planned. N/A	Partially Addressed. This will be assessed during the next compliance review in 2022.

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed or performance declined.

VIII. MCO Strengths and Opportunities, EQR Recommendations, and MCO Responses to Previous Recommendations

Section 438.364(a)(4) of the Title 42 Code of Federal Regulations states that EQR technical reports must include an assessment of strengths and weaknesses, as well as recommendations for each managed care entity. **Table 9** highlights Magellan's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of SFY 2021 EQR activities as they relate to **quality**, **timeliness** and **access**.

Magellan

Table 9: Magellan Strengths and Opportunities, EQR Recommendations, and Magellan Responses to Prior Years Technical Report Recommendations

EQR Activity		Quality	Timeliness	Access
Strengths				
PIPs[1] 1) Monitoring Hospitalization Follow-Up Practices	• 5/6/20 – In 2021, Magellan initiated a training program for Wraparound Facilitators (WF) in order to better facilitate family participation and collaborative Plan of Care development. • 5/6/20 – Family Support Organization (FSO) involvement showed improvement from 2019 to 2020. • The PIP aligns the aim with robust interventions designed to address barriers, and has begun monitoring the progress of interventions using intervention tracking measures, which also monitor provider interventions. • The PIP topic is supported by the rationale and member data on follow-up visits after inpatient psychiatric hospitalization. • The performance indicators are relevant and clearly specified, with supporting procedures to ensure data integrity.	–	**X**	**X**
Compliance with Medicaid and CHIP Managed Care Regulations	Magellan demonstrated full compliance in 9 of the 11 domains.	**X**	**X**	**X**
Performance Measures	Five measures were selected for validation: 1. Follow-Up After Hospitalization for Mental Illness, 2. Number and percent of initial participants who meet the level of care requirements prior to receipt of services, 3. Number and percent of participants whose plan of care was updated when the participant's needs changed, 4. Improved School Functioning, and 5. Utilization of Natural Supports. All five measures passed validation at 100%	**X**	**X**	**X**
Network Adequacy	In June 2021, Magellan met geographic access standards for the provider types reviewed for 100% of its Medicaid membership.	–	–	**X**

EQR Activity		Quality	Timeliness	Access
Opportunities for Improvement				
PIPs	• The 7-Day Follow-Up Hospitalization Rate declined to 46.32% from 52.59% and did not reach the goal of 52.45%. • The 30-Day Follow-Up Hospitalization Rate declined to 63.68% from 72.59% and has not reached target of 73.13%.	X	X	–
Compliance with Medicaid and CHIP Managed Care Regulations	Adequate Capacity and Service – • This requirement is partially addressed in the CSoC unit-Quality Improvement –Clinical Management Program Evaluation (page 174). Barriers identified, interventions, and recommendations for 2020 were clearly laid out. A major intervention was the increase in reimbursement rates for LMHPs, prescribers, and Short-Term Respite providers, which went into effect in July 2019. Grievances and Appeals • Magellan indicated that new revised letter templates were created to satisfy recommendations from the prior year's audit, were approved by LDH on March 3, 2020, and put into use after March 4, 2020. Letter templates prior to this date did not include new revised language. One (1) out of 10 denial notification letters fully met the requirement. Nine (9) out of 10 clinical denial notification letters satisfied 7 of the 8 requirements because letters were sent to members prior to the revised letter format date of implementation and did not include item number 7 of the regulatory requirement on the letters. • The process for appeals did not always provide the member an opportunity to examine their case file, including treatment records, other documents and records considered during the appeals process and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the appeal. Nine (9) out of 10 appeals files met compliance with the requirement. One (1) out of 10 appeal letters did not meet compliance, and the plan acknowledges this was due to a copy and paste error from a case manager. • The former letter template did not include, as parties to the appeal: The member and his or her representative; or the legal representative of a deceased member's estate. One (1) of the 10 appeals files met compliance and nine (9) out of the 10 appeals did not meet compliance because they used older letter templates. • Missing from the documentation is a description of how and under what circumstances providers may file a complaint with the contractor and under what circumstances a provider may file a complaint directly to LDH.	X	–	–

EQR Activity		Quality	Timeliness	Access
Performance Measures	None identified	–	–	–
Network Adequacy	None identified	–	–	–
Performance Measures	None identified	–	–	–
Network Adequacy	None identified	–	–	–
MCO Response to Previous Recommendations				
PIPs	None identified	–	–	–
Compliance with Medicaid and CHIP Managed Care Regulations	Adequate Capacity and Service • Magellan remains committed to members having 100% desired access to all types of providers and services. We will continue evaluating member needs through satisfaction surveys, geographical data, and service utilization. Although the workbook project was delayed due to the recent pandemic, efforts have begun to distribute the workbooks to providers and a refresher presentation on the utilization the tools is scheduled for November 2020. Provider and service needs remain as agenda items for the monthly meetings between Magellan, LDH and the Wraparound Agencies. All growth and services needs will continue to be monitored and reported to the Network Strategy Committee. Grievances and Appeals • The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this requirement. • Quality control procedures were implemented to ensure integrity of the UM letter templates is maintained as evidenced by the following procedure, letter template, and training documents. • The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this requirement.	**X**	–	**X**
Performance Measures	None identified	–	–	–
Network Adequacy	None identified	–	–	–

LDH: Louisiana Department of Health; CSoC: coordinated system of care; ITM: intervention tracking measure; PIP: performance improvement project; SFY: state fiscal year.

IX. Appendix

Table A1: Geographic Classification on Last Day of the Year 2020

Member Group	Number	Percent
Urban/Suburban	675	31.08%
Rural	1,497	68.92%
Total	2,172	100.00%

Table A2: Gender of CSoC Members

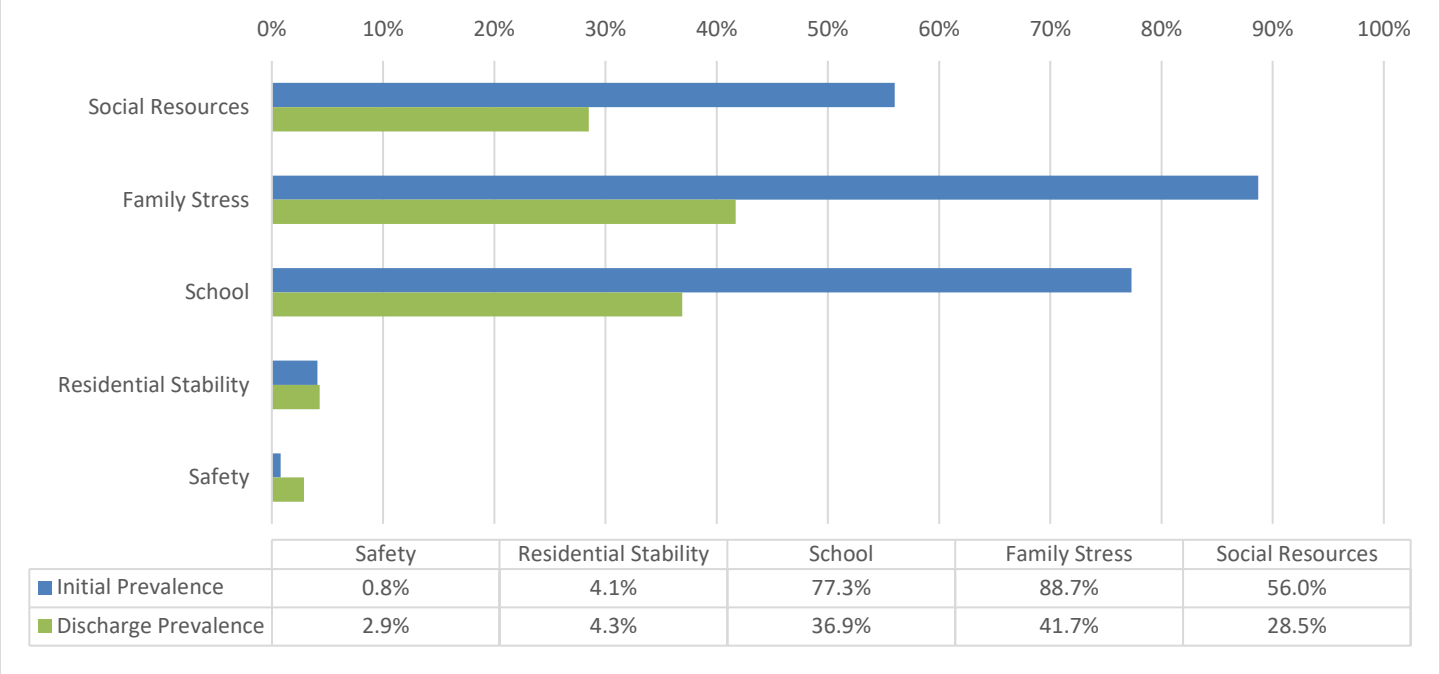
Member Group	2019		2020	
Gender	Number	Percent	Number	Percent
Female	1,791	40.59%	1,452	41.14%
Male	2,621	59.41%	2,077	58.86%
Total	4,412	100.00%	3,529	100.00%

Table A3: Race of CSoC Members

Member Group	2019		2020	
Race	Number	Percent	Number	Percent
Black/African American	2,503	56.73%	1,948	55.20%
White	1,697	38.46%	1,407	39.87%
Multi-Racial	78	1.77%	58	1.64%
Other/Single Race	48	1.09%	53	1.50%
American Indian/Alaskan Native	25	0.57%	19	0.54%
Native Hawaiian/Pac Islander	10	0.23%	9	0.26%
Asian	10	0.23%	6	0.17%
Unknown	41	0.93%	29	0.82%
Total	4,412	100.00%	3,529	100.00%

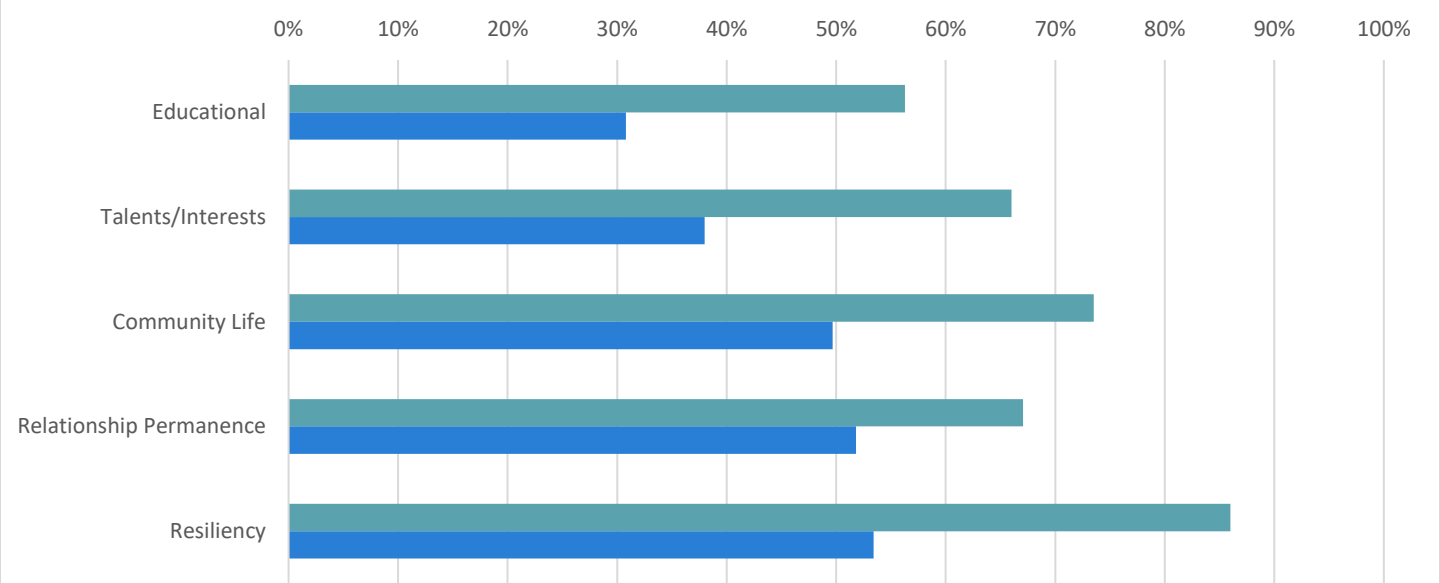
Table A4: Ethnicity of CSoC Members

Member Group	2019		2020	
Ethnicity	Number	Percent	Number	Percent
Non-Hispanic/Non-Latino	4,528	96.51%	3,403	96.43%
Hispanic/Latino	95	2.15%	88	2.49%
Unknown	59	1.34%	38	1.08%
Total	4,412	100.00%	3,529	100.00%



	Safety	Residential Stability	School	Family Stress	Social Resources
Initial Prevalence	0.8%	4.1%	77.3%	88.7%	56.0%
Discharge Prevalence	2.9%	4.3%	36.9%	41.7%	28.5%

Figure A1: Social Determinants of Health – Risk Factors



	Resiliency	Relationship Permanence	Community Life	Talents/Interests	Educational
Initial Prevalence	85.99%	67.06%	73.51%	66.00%	56.27%
Discharge Prevalence	53.41%	51.80%	49.67%	38.00%	30.81%

Figure A2: Social Determinants of Health – Protective Factors

Table A5: Analysis of Disproportionate Under-Representation—30-Day Follow-Up Hospitalization (FUH) Rate

					Disproportionate Index	The Proportionality Index (PI)
Subpopulation	# of Unique Enrollees in Denominator	% of TOTAL Denominator	# of Unique Enrollees in Numerator	% of TOTAL Numerator	% of TOTAL Denominator ÷ % of TOTAL Numerator	% of TOTAL Numerator ÷ % of TOTAL Denominator
MCO Total	380	100.00%	242	100.00%	–	–
Female	222	58.42%	148	61.16%	95.53%	1.05%
Male	158	41.58%	94	38.84%	107.04%	0.93%
American Indian or Alaska Native	1	0.26%	1	0.41%	63.68%	1.57%
Asian	1	0.26%	1	0.41%	63.68%	1.57%
Black or African American	174	45.79%	111	45.87%	99.83%	1.00%
Native Hawaiian or Pacific Islander	0	0.00%	0	0.00%	–	–
White	191	50.26%	120	49.59%	101.36%	0.99%
Other	11	2.89%	7	2.89%	100.08%	1.00%
Unknown	2	0.53%	2	0.83%	63.68%	1.57%
Hispanic	11	2.89%	7	2.89%	100.08%	0.99%
Non-Hispanic	365	96.05%	231	95.45%	100.63%	0.99%
Unknown	4	1.10%	4	1.80%	63.68%	1.57%
Yes (i.e., English)	376	98.95%	239	98.76%	100.19%	1.00%