External Quality Review Annual Technical Report Magellan of Louisiana CSoC Program

State of Louisiana Office of Behavioral Health

State Fiscal Year 2022

Review Period: July 1, 2021–June 30, 2022

April 2023

Table of Contents

I. EXECUTIVE SUMMARY I-4

Purpose of Report I-4
Scope of External Quality Review Activities Conducted I-4
High-Level Program Findings and Recommendations I-5
Conclusion I-7
Recommendations for Magellan I-7

II. LOUISIANA MEDICAID MANAGED CARE PROGRAM II-8

Managed Care in Louisiana II-8
Findings from an Effectiveness Evaluation of the State's Medicaid Quality Strategy II-9
Responsibility for Quality Monitoring II-9
Health Disparities II-10
IPRO's Assessment of the Louisiana Medicaid Quality Strategy II-12
Recommendations II-15

III. VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS III-16

Objectives III-16
Technical Methods of Data Collection and Analysis III-17
Description of Data Obtained III-18
Conclusions and Comparative Findings III-18

IV. VALIDATION OF PERFORMANCE MEASURES IV-24

Objectives IV-24
Technical Methods of Data Collection and Analysis IV-24
Description of Data Obtained IV-24
Conclusions and Findings IV-24

V. REVIEW OF COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS V-26

Objectives V-26
Technical Methods of Data Collection and Analysis V-26
Description of Data Obtained V-27
Conclusions and Findings V-27

VI. VALIDATION OF NETWORK ADEQUACY VI-29

Objectives VI-29
Technical Methods of Data Collection and Analysis VI-29
Description of Data Obtained VI-29
Conclusions and Comparative Findings VI-30

VII. EQRO'S ASSESSMENT OF MCO RESPONSES TO THE PREVIOUS EQR RECOMMENDATIONS VII-31

Magellan Response to Previous EQR Recommendations VII-31

VIII. MCO STRENGTHS AND OPPORTUNITIES, EQR RECOMMENDATIONS, AND MCO RESPONSES TO PREVIOUS RECOMMENDATIONS VIII-34

IX. APPENDIX A MAGELLAN HEALTH DISPARITIES IX-37

X. APPENDIX B MAGELLAN NOT MET COMPLIANCE REVIEW ELEMENTS X-42

List of Tables

TABLE 1: MAGELLAN PIP SUMMARY, 2021–2022 ....III-18
TABLE 2: MCO PIP INTERVENTION TRACKING MEASURES – MONITORING HOSPITALIZATION FOLLOW-UP PRACTICES III-20
TABLE 3: PIP VALIDATION RESULTS FOR PIP ELEMENTS III-21
TABLE 4: ASSESSMENT OF MAGELLAN PIP INDICATOR PERFORMANCE III-23
TABLE 5: MAGELLAN PERFORMANCE MEASURES IV-25
TABLE 6: AUDIT RESULTS BY AUDIT DOMAIN V-28
TABLE 7: GEOACCESS PROVIDER NETWORK ACCESSIBILITY VI-30
TABLE 8: IPRO ASSESSMENT DETERMINATION LEVELS VII-31
TABLE 9: MAGELLAN RESPONSE TO PREVIOUS EQR RECOMMENDATIONS VII-31
TABLE 10: MAGELLAN STRENGTHS AND OPPORTUNITIES, AND EQR RECOMMENDATIONS VIII-34

Healthcare Effectiveness Data and Information Set (HEDIS®) and *Quality Compass®* are registered trademarks of the National Committee for Quality Assurance (NCQA). The HEDIS Compliance Audit™ is a trademark of the NCQA.Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). Triple Aim® is a registered trademark of the Institute for Healthcare

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 § 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) 2022 EQR activities for Magellan of Louisiana, which furnishes Coordinated System of Care (CSoC) for Louisiana's services in the state. The period under review is SFY 2022 (July 1, 2021–June 30, 2022).

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 was 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, require each state to assess their MCOs' information system (IS) capabilities. The regulations at *Title 42 CFR § 438.242* and *457.1233(d)* also require the state to ensure that each MCO 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 § 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.

(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.

[1] prepaid inpatient health plan.

[2] prepaid ambulatory health plan.

[3] primary care case management.

(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 2021–2022 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 2022 demonstrated that LDH and 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 Magellan's PIP confirmed the state's compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The result of the validation activity determined that Magellan partially or fully met all validation requirements, except for the Next Steps section; however, the latter was addressed in a plan for a revised PIP that was agreed upon by LDH and Magellan in a 6/9/2022 teleconference. In SFY 2022, the following strengths were identified:

- The validation findings generally indicate that the credibility of the PIP results is not at risk.
- Three intervention tracking measures showed improvement.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

IPRO developed a tool for review based on *Title 42 CFR § 438.206*. Magellan demonstrated full compliance in 7 of the 12 domains. Fully compliant domains include: Coverage and Authorization of Services, Grievance and Appeal Systems, Subcontractual Relationships, Practice Guidelines, Health Information Services, Quality Assessment and Performance Improvement, and Fraud, Waste and Abuse. The overall compliance score for Magellan was 97.8%.

Performance Measures

IPRO's validation of the MCO's performance measures (PMs) confirmed the state's compliance with the standards of *Title 42 CFR § 438.330(a)(1).* The results of the validation activity determined that the MCO was compliant with the standards of *Title 42 CFR § 438.330(c)(2)*. Of note, only the Follow-up After Hospitalization for Mental Illness (FUH01) is considered a true quality performance measure.

Five measures were selected for validation, and all five measures passed validation at 100%:
1. Follow-up After Hospitalization for Mental Illness (FUH01),
2. Number and percent of participants whose level of care determination form was completed timely as required by the state (LOC02),
3. Number and percent of participants whose plans of care were updated timely, as specified in the waiver application (POC04),
4. Number and percent of participants who received information on available HCBS, as documented by the participant/authorized representative's signature on the State approved form (POC08), and
5. Access to Wraparound (QM12).

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 MCE and a plan of action to correct deficiencies must be submitted.

In the June 2022 GeoAccess Report, Magellan met GeoAccess standards specified in the state contract for the Outpatient Services reviewed for 100% of its Medicaid membership. However, for the other provider types it did not meet the GeoAccess standards. 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
Magellan has requested an additional year to conduct their PIP in order to address the lack of improvement attributed to the 2019 novel coronavirus (COVID-19) public health emergency (PHE) challenges; however, it is not clear that missed opportunities for improvement did not influence the lack of progress. The Next Steps section was not completed and should address the Final Review comments with plans for next steps.

There was a missed opportunity to use disproportionate analysis findings to inform tailored and targeted interventions informed by barrier analysis, as well as a missed opportunity to use ongoing barrier analysis triggered by concurrent intervention tracking measure (ITM) analysis to inform ongoing modifications to interventions.

Review of Compliance with Medicaid and CHIP Managed Care Regulations
Magellan demonstrated less than full compliance in 5 of the 12 domains. The domains not met in full included: Coordination and Continuity of Care (90.0%), Availability of Services (95.1%), Provider Selection (95.2%), Assurances of Adequate Capacity and Services (97.9%), and Enrollee Rights and Protections (97.7%). A full list of elements Not Met are in **Appendix B**.

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

Network Adequacy
None identified.

Conclusion

Findings from SFY 2022 EQR activities highlight the MCE'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 demonstrated strengths in the areas of quality, access, and timeliness through full compliance with 7 of 12 domains in the compliance audit, 100% validation of the PMs 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.

Performance Improvement Projects

It is recommended that LDH's decision regarding Magellan's request to continue the PIP be based on the extent that the Next Steps address these comments and demonstrate a robust approach to interventions based on lessons learned. In addition, goals should be set higher as recommended in the review comments.

Compliance with Medicaid and CHIP Managed Care Regulations

For details of recommendations for Magellan for compliance elements that received a "Not Met" determination, refer to **Appendix B**.

II. Louisiana Medicaid Managed Care Program

Managed Care in Louisiana

On February 1, 2012, 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 (MMC) 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 (BH) 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 BH PIHP (managed by Magellan of Louisiana CSoC Program) to help children with BH challenges that are at risk for out-of-home placement.

The CSoC offers an array of Medicaid State Plan and Home- and Community-Based Services (HCBS) Waiver 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 HCBS 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 1.8 million enrollees, approximately 35% of the state's population. There are five statewide MCOs: ABHLA, ACLA, HBL, LHCC, and UHC. In February 2020, the state announced its intent to contract with two dental PAHPs for Medicaid following a state bid process that began in June 2019

when LDH 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 MMC contracts.

Healthy Louisiana covers more than 90% of Louisiana Medicaid members, including nearly 750,000 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 MCOs also provide case management services and certain value-added Medicaid benefits. Healthy Louisiana statewide enrollment increased by 4.7% from 1,733,148 in June 2021 to 1,814,431 in June 2022 (data not shown).

Findings from an Effectiveness Evaluation of the State's Medicaid Quality Strategy

Louisiana's Medicaid 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 2022 Medicaid Quality Strategy identifies the following three aims:

- **Better Care**: Make health care 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; and
- **Smarter Spending:** Demonstrate good stewardship of public resources by ensuring high-value, efficient care.

The current Louisiana Department of Health 2022 Medicaid Quality Strategy is available for viewing on its 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). OBH has a memorandum of understanding (MOU) with Medicaid to oversee and manage the Medicaid BH service system. 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 MMC Quality Strategy.

The Louisiana 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 (CHIP) enrollees. Members of the Medicaid Medical Care Advisory Committee and its subcommittees fulfill the role required by federal regulation *Title 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, 2021–June 30, 2022:

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)?

[Note that the responses below are Magellan's submission verbatim. See **Appendix A** for table and chart references.]

Numerous studies have evidenced disparities in access to, use, and quality of behavioral health services. Occurring among minority populations, individuals of low socioeconomic status, and those residing in rural areas, these studies conclude that such disparities significantly impact both short and long-term health outcomes. The CSoC program is in a unique position to intrinsically and directly addresses many of the known disparities in health services experienced by minority populations living in Louisiana. This is accomplished through partnering with nine regional Wraparound Agencies and the youth and families they serve to develop and implement a care plan that is guided by the practices and principles of the Wraparound model. This document provides an overview of activities undertaken by Magellan during fiscal year 2021/2022 to address disparities in access to care and quality of care.

Access to Care

Member Demographics. As the CSoC Contractor, Magellan conducts an annual population assessment to examine the characteristics of enrolled youth to ensure that minority populations are appropriately and equitably represented. Tables 1 – 4 below provide a frequency distribution of membership by gender, race, and ethnicity for calendar years 2020 and 2021. Highlights from the assessment are bulleted below.

- In the 2020 census, the two main racial groups in Louisiana were white (i.e., 62.4%) and Black/African American, which represented 62.4% and 33.0% of the citizens, respectively[1].
- Medicaid enrollment by race for fiscal year 2020/21 showed that enrollees are about 41.2% Black/African American, 33.2% are White and 25.6% are Other.[2]
- Black/African American youth represented 53.1% of CSoC youth in 2021, higher than in general and Medicaid populations.
- CSoC has also shown capacity to connect and engage with youth and families residing in rural areas, a known predictor of decreased access to care. According to the 2010 census[3], 26.8% of the Louisiana population resided in rural settings, yet more than 70% of CSoC youth live in rural areas. This demonstrates the effectiveness of the CSoC program's increased access to behavioral health services for vulnerable youth and families in Louisiana.

Direct Referrals. Since 2015, members and providers have consistently reported that the referral process into CSoC was cumbersome and difficult. This was primarily because Healthy Louisiana Plans (HLPs) were required to be the single point of contact for referrals, necessitating a warm transfer to Magellan to complete the referral. In 2021, Magellan piloted an initiative to receive direct referrals from DCFS, OJJ, a psychiatric residential treatment facility, and an inpatient hospital and their emergency room. Results were presented to LDH, which showed a reduction in average call time, a decrease in abandonment rate, and positive feedback from all referral sources. Following the pilot, LDH approved Magellan to expand direct referrals to all referral sources beginning September 2021. Since implementation of direct referrals in Q4 2021, a substantial increase in referrals has occurred. This change is depicted in Figure 1 below, which shows referrals increased from 421 to 1,022 from Q3 to Q4 2021. When compared to the average number of referrals received between Q1 – Q3 (N = 453), this represents an increase of 125.61%. Direct referrals allow for Magellan and WAAs to identify and refer youth and families with much greater ease and convenience.

Attendance of Follow-up Appointment After Inpatient Hospitalization (FUH). To assess potential disparities in access to care after an inpatient hospitalization, 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 01/01/2021 to 12/31/2021. 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 5 below, 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.

Member POC Implementation Surveys. Wraparound Facilitators contact youth and caregivers at least once per month to ensure services are provided in accordance with their POCs. If barriers are reported, facilitators must work with providers to resolve them or assist youth and caregivers to find a new provider. The survey results are aggregated monthly to detect and address aberrant trends impacting access to care. In 2021, more than 92% of youth and caregivers reported their plans were being implemented as needed, which exceeded the minimum performance threshold of 90%, established by LDH.

Quality of Care

Improvement in Clinical Functioning. One of the primary ways CSoC monitors achievement of program goals and improvements in clinical functioning is through data collected during the assessment process. The CANS assessment is administered at enrollment and every 180-days thereafter, and at discharge.

Clinical improvement is defined as a decrease of five or more points in global CANS score from initial to discharge assessments. Of those discharging from CSoC in 2021, 71.7% of CSoC youth demonstrated a CANS global score improvement of 5 or more points from initial to discharge assessment (N = 952). When examining the results by the program's two largest racial groups, clinical improvement in 70.89% of African American youth (N = 726) was observed, as compared to 69.57% in White youth (N = 631). A chi- square test of independence was performed to examine the relationship between the two groups. It indicated no statistically significant difference, X2 (1, $N = 1375$) = 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 Child and Adolescent Needs and Strengths (CANS) is administered at enrollment and at least every 180 days thereafter. The assessment includes identification of specific social determinants of health impacting each youth and family. Magellan uses CANS data to identify areas of need in our membership and monitor effectiveness of the program to support youth and families in resolving those needs. The effectiveness of the CSoC program in countering negative impacts of social determinants of health is monitored by comparing the prevalence rates of actionable needs (risk factors) and strengths items (protective factors) at initial and discharge CANS assessments for youth discharging in calendar year 2021 (n=1,327). 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 2 below shows the quantitative change rate from initial to discharge assessments for a subset of risk factors (i.e., Family Stress, Access to Social Resources, Relationship Permanence, School Functioning, and Adjustment to Trauma). Analysis shows that the prevalence of actionable needs identified on the CANS was markedly reduced from initial to discharge assessments in all risk areas.

Figure 3 below shows the quantitative change rate between initial and discharge assessments for youth discharging from CSoC in 2021 for a subset of protective factors (i.e., Resiliency, Talents/Interests, Educational, Caregiver Knowledge, and Optimism). Improvements were seen across all selected protective factors. The greatest change in 2021 was observed in resiliency, with 89.10% of youth evidencing need for increased resiliency at intake assessment and only 51.50% at discharge. This means that the rate of youth reported to have either no identifiable resiliency strengths or no ability to effectively utilize that strength was reduced by 37.6 percentage points from initial to discharge assessments.

Quality Improvement Activity. In 2019, Magellan initiated a formal QIA aimed at improving the effectiveness of POCs in addressing actionable clinical needs as defined by the POC Review Tool, a standardized measurement tool. Magellan LMHPs complete POC Review Tools for a representative sample by region and POC type (i.e., initial or reassessment) for approximately 75% of clinical eligibility determination reviews. Baseline data was collected from 07/01/2019 to 06/30/2020, with Remeasurement 1 (R-1) collected from 07/01/2020 to 06/30/2021 and Remeasurement 2 (R-2) from 07/01/2021 to 06/30/2022.Table 6 and Figure 4 below show statistically significant improvements (p <.05) for all 4 indicators, ranging from 8.9 to 25.9 percentage points. These significant improvements demonstrate of the effectiveness of Magellan's Care Management review process in improving the quality of POCs.

[1]U.S. Census Bureau, 2020 Census, Louisiana - Census Bureau Profile. Retrieved January 1, 2023.
[2] MedicaidAnnualReport2021.pdf (la.gov); Retrieved January 1, 2023.
[3] U.S. Census Bureau, 2010 Census, PCT2: URBAN AND RURAL - Census Bureau Table. Retrieved January 1, 2023.

IPRO's Assessment of the Louisiana Medicaid Quality Strategy

Evaluation Methodology

To evaluate Louisiana's *2021 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 (PQIs), 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 LDH 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 EQR report documents, including a guide to choosing a Medicaid plan, PM results, annual EQR technical reports, access and availability survey findings and a BH member satisfaction survey.

Third, IPRO evaluated state-MCO-EQRO communications by reviewing online data sources. In addition to the LDH and EQR 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 PIP 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*. Other LDH department-wide quality initiatives, such as Taking Aim at Cancer in Louisiana, Louisiana Perinatal Quality Collaborative, Opioid Strategy and Hepatitis C Elimination Strategy were also reviewed.

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

Strengths

- Louisiana's *2021 Medicaid Managed Care Quality Strategy*, updated May 2021, is based on aims, goals, and objectives to promote improvement in health care delivery and outcomes, along with metrics by which progress in attaining the goals can be quantitatively measured.
- Quality metrics used to assess progress in achieving the quality strategy's goals were derived from all five Healthy Louisiana MCOs required to annually report quality PMs including HEDIS quality metrics, CMS Adult and Children Core Data Sets, AHRQ PQIs, CAHPS consumer satisfaction measures, and several state-specified quality measures. The following strengths are identified by goal:
    - *Ensure access to care to meet enrollee needs:* 4 (33%) of the 12 statewide average (SWA) rates met or exceeded the national Medicaid 50th percentile target objective.
    - *Facilitate patient-centered, whole person care:* All (100%) SWA rates for the three measures for this goal met or exceeded the national Medicaid 50th percentile target objective.
    - *Promote wellness and prevention:* 17 (37%) of the SWA rates with benchmarks met or exceeded the national Medicaid 50th percentile target objective, and three SWA rates met the improvement objective.
    - *Improve chronic disease management and control:* Two (11%) SWA rates met or exceeded the national Medicaid 50th percentile target objective, and seven (41%) SWA rates for this goal met the improvement objective.
    - Overall, there were 26 (32%) SWA rates out of a total of 81 measures with benchmarks that met the target objective, and 11 (14%) SWA rates that met the improvement objective out of a total of 77 rates that could be trended. SWA rates for one of the measures (COPD or Asthma in Older Adults Admission Rate) met both the national target and the improvement objective.
- LDH continues to report on a robust set of monitoring activities including enrollment, network adequacy, quality of care, member satisfaction, program transparency, medical loss ratio, claims, and diabetes and obesity.
- The EQRO monitoring reports included a guide to choosing a health plan; PM results and analysis; two network access and availability provider surveys; and a BH member satisfaction survey. In compliance with federal regulations, the EQRO prepared federally required MCO annual technical reports (ATRs). Results for each MCO; a state MCO aggregate; a dental benefit aggregate; and a Magellan CSoC Program report are posted on the LDH website at https://ldh.la.gov/assets/medicaid/EQRO/2022/AnnualTechnicalReport2020-2021MagellanFinal.pdf .
- A high level of compliance with time and distance standards was reported in the aggregate ATR for all MCOs for primary care providers (PCPs). All five MCOs reported 100% compliance with time and distance access standards to adult PCPs for members in rural areas within 30 miles and 60 minutes. All five MCOs also met 100% compliance with time access standards to pediatric providers and ob/gyn providers for members in rural areas within 60 minutes. Four of the five MCOs met 100% compliance with distance access standards to pediatric PCPs for members in rural areas within 30 miles.
- 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 the use of ITMs 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.
- LDH effectively collaborates with other LDH department-wide initiatives for the benefit of Healthy Louisiana members.

Opportunities for Improvement

- Opportunities for improvement are evident for numerous quality metrics identified by the following Quality Strategy goals:
    - *Ensure access to care to meet enrollee needs:* Five of the six SWA rates evaluated for improvement showed a decline in rates between measurement year (MY) 2019 and MY 2020. The statewide average rates for all four age groups of the Adults' Access to Preventive Ambulatory Health Services (AAP) did not meet either the target objective or the improvement objective: AAP: 20–44 years; 45–64 years; 65+ years and total.
    - *Improve coordination and transitions of care:* Of the five SWA rates in this measure set, there was no improvement in Plan All-Cause Readmission SWA rates for observed readmissions or for expected readmission rates; and SWA rates for the two Follow-up After Hospitalization for Mental Illness (FUH) measures did not meet either the target or the improvement objective.
    - *Facilitate patient-centered, whole person care:* While all of the SWA rates for the three measures in this goal met or exceeded the national Medicaid 50th percentile, none of the measures improved by at least 2.0 percentage points (pps).
    - *Promote wellness and prevention:* Opportunities for improvement are evident for the 26 SWA rates in this measure set (57%) that did not meet either the target objective or the improvement objective:
        - PPC: Timeliness of Prenatal Care;
        - Low-Risk Cesarean Delivery;
        - Initiation of Injectable Progesterone for Preterm Birth Prevention;
        - Percentage of Low Birth Weight Births;
        - CIS: DTap; Pneumococcal conjugate; Hepatitis A; Influenza; Combination 4, 6, 7, 8, 9 and 10;
        - FVA: Flu Vaccinations for Adults Ages 18 to 64;
        - WCC: BMI Percentile Total;
        - All six of the CCP: Contraceptive Care – Postpartum measures;
        - CCS: Cervical Cancer Screening; and
        - all three of the Medical Assistance with Smoking and Tobacco Use Cessation measures.
    - *Improve chronic disease management and control:* Opportunities for improvement are evident for the nine SWA rates in this measure set (53%) that did not meet either the target objective or the improvement objective:
        - Three PQI rates: Diabetes Short-term Complications; Heart Failure Admission; Asthma in Younger Adults Admissions;
        - CDC: Hemoglobin (HbA1c) Testing; HbA1c Poor Control (> 9.0%); HbA1c Control (< 8.0%);
        - HIV Viral Load Suppression; and
        - ADD: Initiation and Continuation and Maintenance Phases.
- Several core measures listed in the 2021 Quality Strategy were identified as indicators, but MY 2020 data were not collected or available, including several HEDIS measures as well as other measures developed by AHRQ, CMS and the state as listed in **Table 3**. Including these measures in the required MY 2021 measure set will provide a more complete evaluation of how well the Healthy Louisiana MMC Program is doing in achieving its quality strategy goals.
- As reported in the *FY 2021 Aggregate Annual Technical Report*, the percent of members in urban areas meeting the time and distance access standards to adult PCPs, pediatric providers and obstetricians/gynecologists (ob/gyns) was less than 100% for all five MCOs. Opportunities for

improvement for all MCOs are particularly evidenced for access to ob/gyns by distance for members in urban areas and for all but one MCO for access to ob/gyns by distance in rural areas.
- The access and availability provider surveys, conducted by the EQRO, found that overall compliance with timeliness requirements were substantially below the MCO contracted timeliness standards. For ear-nose-throat (ENT) and cardiology specialists, overall compliance with timeliness standards was 36.2% for routine calls and 7.5% for non-urgent calls. For gastroenterologists, urologists and ob/gyns, the overall compliance with timeliness standards was 24.7% for routine calls and 4.6% for non-urgent calls.
- The low overall response rates for the *Healthy Louisiana Behavioral Health Member Satisfaction Survey* conducted by the EQRO resulted in recommendations for the state regarding sampling methodology and survey questions.

Recommendations

It is recommended that LDH, in collaboration with the EQRO and the MCOs, address the above listed opportunities for improvement and the following recommendations:

- Overall, LDH is successfully implementing the *2021 Quality Strategy*, which includes a thorough set of HEDIS, CAHPS and state-specific measures to assess quality performance, along with well-considered targets for achievement and improvement. The measure set is now specifically aligned with the strategy goals and objectives which should allow LDH to better evaluate their level of success in achieving the stated goals. Requiring the MCOs to submit all the measures listed in the *2021 Quality Strategy* measure set for MY 2021 will enable LDH and the EQRO to better prepare a more complete assessment of how well the Healthy Louisiana MMC Program is doing in achieving its goals.
- LDH should examine each of the measures with SWA rates that are not improving over time or that are below the desired benchmarks. To prioritize where improvement is most needed, LDH could start with the measures that did not meet either the target or the improvement objective. Out of the 74 measures where the target and the improvement objective could be assessed, 41 (55%) of the SWA rates did not meet either objective. Another focus could be directed at the low level of improvement evidenced by only 11 (14%) SWA rates that improved from the prior year's rate by at least 2.0 pps. Further analysis by MCO may indicate whether poor performance is mainly a problem with one or two MCOs, or if it is an issue for most MCOs. Conducting barrier analysis on these prioritized areas may suggest the need to implement interventions such as future PIPs or focus clinical studies.
- The access and availability survey results continue to indicate a need to further address provider network adequacy, which was identified in both survey reports as a common problem. LDH may want to consider methods of supporting the MCOs in their outreach to recruit providers, especially specialists and subspecialists in urban areas. It should also be noted that Network Adequacy Validation is a mandatory EQR activity, but CMS has not yet published a protocol to support the activity. Once the protocol is created, states will have 1 year to begin implementation. LDH could consider initiating validation activities such as regular provider directory and web-based directory validations and/or provider and member focus groups to better understand the barriers both providers and members encounter in providing and/or accessing medical services through Louisiana's MMC system.

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' 2021/2022 PIPs confirmed the state's compliance with the standards of *Title 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.

PIPs 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 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 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. has 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. Aims/Goals/Objectives
   a. Aims specify performance indicators for improvement with corresponding goals.
   b. Goals set target improvement rates that are bold, feasible, and based upon baseline data and strength of interventions, with rationales (e.g., benchmarks).
   c. Objectives align aim and goals with interventions.
3. Methodology
   a. Annual PMs are indicated.
   b. Methodology specifies numerator and denominator criteria.
   c. Procedures indicate data source, hybrid versus administrative, and reliability.
   d. Sampling method is 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. direct member input from focus groups, quality meetings, surveys, and/or care management outreach;
    c. 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 that
    a. are informed by barrier analysis;
    b. target members, providers, and MCO;
    c. are new or enhanced, starting after baseline year; and
    d. have corresponding monthly or quarterly ITMs to monitor progress of interventions.
6. Results table has
    a. performance indicator rates with numerators and denominators; and
    b. goal rates.
7. Discussion includes an 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 include
    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 MCO. 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
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 PIP 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, 2021–June 30, 2022). Final PIP results were not due during the ATR review period.

Table 1: Magellan PIP Summary, 2021–2022

Magellan PIP Summaries
PIP 1: Monitoring Hospitalization Follow-Up Practices **Validation Summary:** The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the ITM and Disproportionate Under-representation data analysis issues identified in the review comments.
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. **Interventions during the ATR period** • Member Barriers Identified: It was discovered that families across the state often do not actively participate in the hospitalization process for CSoC youth. Through the barrier analysis discussions, it was explained that the families are burned out emotionally from the extreme nature of the youth's problematic behavior. This lack of participation also affects the WAA's ability to collaborate with the hospital, facilitate engagement aspects of wraparound with the family, and reinforce team goals for the youth and family. The Family Support Organization (FSO) did not always receive notification when assigned youth were admitted to the hospital which limited their ability to

Magellan PIP Summaries
engage and support the family during the hospitalization. Because the families are not involved with the hospitalization, the aftercare recommendations were not always understood or followed. Several families felt that aftercare appointments were made without consideration for their limitations (transportation, guardian employment demands, distance to providers, etc.). • Interventions to address member barriers: Magellan will be providing additional training events to the WAAs focusing on enhanced skill development regarding the family engagement phase of wraparound. The training will also educate on skills that develop partnerships with hospitals and reinforce actions during hospitalizations that improve family adherence to aftercare recommendations (improved crisis planning, obtaining consents, attending family sessions, holding CFTs at hospital, assist with discharge planning and appointment scheduling). Magellan has initiated daily reporting to the FSO of assigned youth hospitalizations to enable immediate family contact for assistance and support. • Provider Barriers Identified: Newly referred youth with intense behavioral risks and needs often result in inpatient admissions due to families being overwhelmed and exhausted and unable to cope with ongoing crises. Recognizing this history can trigger a relapse for youth/families preparing to graduate from CSoC. Providers and hospitals may not be aware of the ability and scope of assistance available from Magellan to help expedite communication regarding recommendations for the youth. • Interventions to address provider barriers: Magellan has begun holding Root Cause Analysis staff meetings between Magellan Clinical and Quality staff, including the medical director, and WAA directors, supervisors, and facilitators to discuss needs for youth experiencing frequent hospitalizations or have other high-risk characteristics identified. These staff meetings enable shared brainstorming of how Magellan and the WAA can work together to get needed services in place by either identifying providers and/or expediting needed authorizations. Magellan has continued internal clinical discussions for youth with recent history of hospitalizations, reviewing medical and psychiatric history and current treatment recommendations, specialized services needed, facilitating connection to providers, and supports available during crises. **Performance Improvement Summary** *Strengths:* • 5/13/22- ITM 1 (Wraparound Coordinator follow-up calls to member) increased from 20.0% Y2 Q3 to 26.67% Y3 Q2 and ITM 5 (Youth connection with MHP prior to inpatient stay) increased from 76.36% Y2 Q3 to 77.78% Y3 Q3; youth connection with MHP prior to inpatient stay was also reported by Magellan to be statistically associated with attendance at a follow-up appointment. • 5/13/22- The highest ITM rates were observed for ITM 2 (POC), ITM 4 (FSO within 7 days) and ITM 5 (prior MH appointment). *Opportunities for Improvement:* See **Table 3** below.

Table 2 shows the trend in intervention tracking measure rates implemented during the review period by quarter.

Table 2: Magellan PIP Intervention Tracking Measures – Monitoring Hospitalization Follow-Up Practices

Intervention Tracking Measure	March 2021	June 2021	September 2021	December 2021	March 2022
Wraparound Coordinator follow-up calls to member/guardian within seven days of discharge Num: Successful contacts Denom: Total number hospitalized youths	Numerator = 22 Denominator = 110 Rate = 20.0%	Numerator = 21 Denominator = 128 Rate = 16.41%	Numerator = 18 Denominator = 80 Rate = 22.50%	Numerator = 28 Denominator = 105 Rate = 26.67%	NA
POC Crisis Plan Reviewed/Updated post hospitalization Num: Number of Crisis POCs submitted Denom: Number of admissions	Numerator = 57 Denominator = 110 Rate = 52.25%	Numerator = 53 Denominator = 128 Rate =41.41%	Numerator = 42 Denominator = 80 Rate = 52.50%	Numerator = 60 Denominator = 105 Rate = 57.14%	Numerator = 55 Denominator = 108 Rate = 50.93%
FSO engagement with caregiver/guardian during hospitalization Num: Youth with FSO parent support claims during hospitalization Denom: Total number hospitalized youth with active FSO parent support authorization	Numerator = 63 Denominator = 95 Rate = 66.32%	Numerator = 60 Denominator = 106 Rate = 56.60%	Numerator = 33 Denominator = 60 Rate = 55.00%	Numerator = 55 Denominator = 88 Rate = 62.50%	Numerator = 53 Denominator = 94 Rate = 56.38%
FSO engagement with youth and caregiver/guardian within 7 days of hospital discharge Num: Youth with FSO parent and/or youth support claims during hospitalization Denom: Total number hospitalized youth with active FSO parent and/or youth support authorization	Numerator = 80 Denominator = 95 Rate = 84.21%	Numerator = 74 Denominator = 106 Rate = 69.81%	Numerator = 44 Denominator = 60 Rate = 73.33%	Numerator = 65 Denominator = 88 Rate = 73.86%	Numerator = 77 Denominator = 94 Rate = 81.91%
Youth connection with MHP prior to inpatient stay. Num: Youth with qualifying FUH type appointment prior to inpatient stay. Denom: Total number of hospitalized youths.	Numerator = 84 Denominator = 110 Rate = 76.36%	Numerator = 104 Denominator =128 Rate = 81.25%	Numerator = 70 Denominator = 80 Rate = 87.50%	Numerator = 80 Denominator = 105 Rate = 76.19%	Numerator = 84 Denominator = 108 Rate = 77.78%

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

PIP Validation Element	PIP 1
Magellan	Monitoring Hospitalization Follow-Up Practices
1. Topic/ Rationale	
a. Impacts the maximum proportion of members that is feasible	M
b. Potential for meaningful impact on member health, functional status or satisfaction	M
c. Reflects high-volume or high risk-conditions	M
d. Supported with MCO member data (baseline rates), e.g., disease prevalence	M
2. Aim	
a. Specifies Performance Indicators for improvement with corresponding goals	M
b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	PM
c. Objectives align aim and goals with interventions	M
3. Methodology	
a. Annual Performance Measures indicated	M
b. Specifies numerator and denominator criteria	M
c. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M
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	PM
b. Obtain direct member input from focus groups, quality meetings, surveys, and/or care management outreach	M
c. Obtain direct provider input from focus groups, quality meetings, surveys, and/or care management outreach	M
d. QI Process data ("5 Why's", fishbone diagram)	PM
5. Robust Interventions that are Measurable using Intervention Tracking Measures	
a. Informed by barrier analysis	PM
b. Actions that target member, provider and MCO	M
c. New or enhanced, starting after baseline year, modified as indicated by stagnating or declining ITM rates	PM
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)	PM
e. One or more member ITMs showed improvement and impact (volume)	PM
f. One or more provider ITMs showed improvement and impact (volume)	PM
6. Results Table (Completed for Baseline, Interim and Final Re-Measurement Years)	
a. Table shows Performance Indicator rates, numerators and denominators	M

PIP Validation Element	PIP 1
Magellan	Monitoring Hospitalization Follow-Up Practices
b. Table shows target rates and rationale (e.g., next highest Quality Compass percentile)	PM
c. One or more performance indicators showed improvement	NM
7. Discussion	
a. Interpretation of extent to which PIP is successful	PM
8. Next Steps	
g. Lessons Learned	NM
h. System-level changes made and/or planned	NM
i. Next steps for each intervention	NM

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

- **2b.** IPRO Review of Final Report on 5/13/22: Partially Met. The SMART Goals for Indicators 1 and 2 are lower than the baseline rate and, although the Stretch Goal is not 10 pps higher than the baseline rate, the target rate aims to meet or exceed the Quality Compass 90th percentile. This translates into a 3.3-pp increase from the baseline rate for Indicator 1 (7-day follow-up), but only a 0.71-pp increase from the baseline rate for Indicator 2 (30 day follow-up). If at least a 3.3-ppincrease is targeted for the more challenging 7-day follow-up, then an equivalent or greater percentage point increase would be feasible for the less challenging 30-day follow-up.

- **4a**. IPRO Review of Final Report on 5/13/22: Partially Met. The Index of Disproportionate Under-representation was calculated and showed that enrollees residing in CSoC Regions 1 and 8 were disproportionately under-represented with regard to follow-up visits, yet a secondary method was applied to discount this finding and, consequently, no specific barrier analysis was conducted, and no tailored and targeted interventions were developed and implemented. In addition, the Discussion section interprets a statistically significant association between youth connection with Magellan prior to inpatient stay and attendance at a follow-up appointment; however, the data table was omitted; therefore, it is assumed that the above Revised Interim Review comment was not addressed.

- **4d.** IPRO Review of Final Report on 5/13/22: Partially Met. Retrospective monthly ITM charts were included; however, the retrospective measure defeats the purpose of monthly intervention monitoring, that is, to concurrently identify stagnating or declining trends, conduct drill down member and provider barrier analysis, and use barrier analysis findings to inform modifications to interventions in real time for ongoing quality improvement throughout the course of the PIP.

- **5a.** IPRO Review of Final Report on 5/13/22: Partially Met. There was a missed opportunity to use disproportionate analysis findings to inform tailored and targeted interventions informed by barrier analysis (see review comments for 4a), as well as a missed opportunity to use ongoing barrier analysis triggered by concurrent ITM analysis to inform ongoing modifications to interventions (see review comment for 4d).

- **5c.** IPRO Review of Final PIP Report on 5/13/22: Partially Met. There was no concurrent ITM monitoring with corresponding modifications to interventions to address drill down barrier analysis conducted in response to stagnating or declining ITM rates.

- **5d.** IPRO Review of Final Report on 5/13/22: Partially Met. The above comments on the Revised Interim Report were not addressed.

- **5e.** IPRO Review of Final Report on 5/13/22: Partially Met. ITM 1 (Wraparound coordinator follow-up calls to member) increased from 20.0% year 2, quarter 3, to 26.67% year 3, quarter 2.

- **5f.** IPRO Review of Final Report on 5/13/22: Partially Met. ITM 5 (Youth connection with Magellan prior to inpatient stay) increased from 76.36% year 2, quarter 3, to 77.78% year 3, quarter 3.

- **6b.** IPRO Review of Final Report on 5/13/22: Partially Met. The SMART Goals for Indicators 1 and 2 are lower than the baseline rate and, although the Stretch Goal is not 10 pps higher than the baseline rate, the target rate aims to meet or exceed the Quality Compass 90th percentile. This translates into a 3.3-pp increase from the baseline rate for Indicator 1 (7-day follow-up), but only a 0.71-pp increase from the baseline rate for Indicator 2 (30 day follow-up). If at least a 3.3-pp increase is targeted for the more challenging 7-day follow-up, then an equivalent or greater percentage point increase would be feasible for the less challenging 30-day follow-up.

- **6c.** IPRO Review of Final Report on 5/13/22: Not Met. Both performance indicators decreased from baseline to final re-measurement.

- **7a.** IPRO Review of Final Report on 5/13/22: Partially Met. See above review comments.

- **8a, b, c.** IPRO Review of Final Report on 5/13/22: Not Met. Next Steps were not indicated. IPRO Update 6/10/22 in response to 6/9/22 teleconference with Magellan: LDH, IPRO and Magellan are in agreement to continue with the PIP topic of improving FUH/transitions in care. The Final PIP Review comments should be addressed in a new PIP proposal, pending guidance from LDH and IPRO.

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
		Monitoring Hospitalization Follow-Up Practices	
Magellan	1	7-Day Follow-Up Hospitalization Rate **Baseline rate**: 52.59% **Final rate:** 46.81% **Target rate:** 50.0%	Target not met, and performance decline demonstrated.
	2	30-Day Follow-Up Hospitalization Rate **Baseline rate:** 72.59% **Interim rate:** 66.67% **Target rate:** 70.0%	Target not met, and performance decline demonstrated.

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

IV. Validation of Performance Measures

Objectives

OBH selects a set of quality report measures to evaluate the quality of care delivered by Magellan for their CSoC members. For calendar year (CY) 2022, OBH required Magellan to report a total of 49 measures. The only measure regarded as a quality performance measure is the Follow-up After Hospitalization for Mental Illness (FUH01).

Title 42 CFR § 438.358(a)(1) and *438.358(b)(ii)* require that these PMs be validated by the state, its agent, or an EQRO. IPRO conducted this activity on behalf of LDH for CY 2022.

Technical Methods of Data Collection and Analysis

IPRO, in consultation with the OBH, selected five PMs reported by Magellan. Third quarter 2021 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 (FUH01)
- Number and percent of participants whose level of care determination form was completed timely as required by the state (LOC02)
- Number and percent of participants whose plans of care were updated timely, as specified in the waiver application (POC04)
- Number and percent of participants who received information on available HCBS, as documented by the participant/authorized representative's signature on the State-approved form (POC08)
- Access to Wraparound (QM12)

Description of Data Obtained

For each measure selected for validation, IPRO requested the universes of cases that met numerator compliance. Magellan uploaded the universes for each of the five measures to IPRO's secure File Transfer Protocol (FTP) site in January 2022. From the universes, IPRO randomly sampled 30 cases for validation for each measure.

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.

IPRO initiated a separate Information Systems Capabilities Assessment (ISCA) in June 2022. 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. The review comprised the following areas:

1) Enrollment System(s) and Processes

2) Claims/Encounter Data System(s) and Processes
3) Provider Data System(s) and Processes
4) Data Integration and Systems Architecture

Table 5 shows rates for the five measures validated.

Table 5: Magellan Performance Measures

Performance Measure	Type of Measure	Reported Rate	Reporting Period
Follow-up After Hospitalization for Mental Illness (FUH)			
7-Day	HEDIS	46.81%	June 2022 (MY 2021)
30-Day	HEDIS	66.67%	June 2022 (MY 2021)
Number and percent of participants whose level of care determination form was completed timely as required by the state (LOC02)	LDH	83%	July 2021-June 2022
Number and percent of participants whose plans of care were updated timely, as specified in the waiver application (POC04)	LDH	100%	July2021-June 2022
Number and percent of participants who received information on available HCBS, as documented by the participant/authorized representative's signature on the State-approved form (POC08)	LDH	100%	July2021-June 2022
Access to Wraparound (QM12)	LDH	82.2%	Apr-June 2022

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

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

Objectives

Federal regulations at *Title 42 CFR § 438.358* delineate that a review of an MCO's compliance with standards established by the state to comply with the requirements of *§ 438 Subpart E* is a mandatory EQR activity. Further, this review must be conducted within the previous 3-year period, by the state, its agent, or the EQRO.

LDH annually evaluates the MCO's performance against contract requirements and state and federal regulatory standards through its EQRO, as well as by an examination of each MCO's accreditation review findings.

The most recent comprehensive review of Magellan covered the review period of January 1, 2021–December 31, 2021. In follow-up to the compliance review), LDH required corrective action plans (CAPs) from Magellan for program areas with deficiencies.

Technical Methods of Data Collection and Analysis

To determine which regulations must be reviewed annually, IPRO performs an assessment of the MCO's performance on each of the federal managed care regulations over the prior 3-year period. Results of both the EQRO reviews and accreditation survey are examined. The following guidelines are used to determine which areas are due for assessment:

- regulations for which accrediting organization standards have been crosswalked and do not fully meet equivalency with federal requirements;
- regulations that are due for evaluation, based on the 3-year cycle;
- regulations for which the MCO received less than full compliance on the prior review by either the EQRO or accrediting organization;
- state- and contract-specific requirements beyond the federal managed care regulatory requirements; and
- areas of interest to the state, or noted to be at risk by either the EQRO and/or state.

Note that Quality Management: Measurement and Improvement – Quality Assessment and Performance improvement (QAPI; *Title 42 CFR § 438.240*) is assessed annually, as is required by federal regulations.

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 12 domains:

	CFR	Domain
1.	438.206	Availability of Services
2.	438.207	Assurances of Adequate Capacity and Services
3.	438.208	Coordination and Continuity of Care
4.	438.210	Coverage and Authorization of Services – UM
5.	438.214	Provider Selection
6.	438.224	Enrollee Rights and Protection
7.	438.228	Grievance and Appeal Systems
8.	438.230	Subcontractual Relationships
9.	438.236	Practice Guidelines
10.	438.242	Health Information Services
11.	438.330	Quality Assessment and Performance Improvement Program (QAPI)
12.	438.608	Fraud, Waste and Abuse

For this audit, determinations of "met," "partially met," "not met," and "not applicable" were used for each element under review. Definitions for these review determinations are:

- Met – The PAHP is compliant with the standard.
- Partially Met – The PAHP is compliant with most of the requirements of the standard but has minor deficiencies.
- Not Met – The PAHP is not in compliance with the standard.
- Not applicable – The requirement was not applicable to the PAHP.

Description of Data Obtained

IPRO conducted the 2022 compliance audits on behalf of the LDH. Full compliance audits occur every 3 years, with partial audits occurring within the intervening years. The last full compliance audit occurred in 2019, and a partial review occurred in 2020. The most recent review period of Magellan's compliance with contractual requirements was January 1, 2021, through December 31, 2021. All documents and case files reviewed were active during this time period. During this review period, Magellan was the only BH PAHP.

In advance of the review, IPRO requested documents relevant to each standard under review to support each MCO's compliance with federal and state regulations and contract requirements. This included items such as: policies and procedures; sample contracts; annual QI program description, work plan, and annual evaluation; member and provider handbooks; access reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis, and follow-up. Supplemental documentation was also requested for areas where IPRO deemed it necessary to support compliance.

For this audit, compliance determinations of "Met," "Partially Met," "Not Met, 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**.

Conclusions and Findings

Magellan demonstrated full compliance in 7 of the 12 domains (**Table 6**). The domains that were not met in full includes Coordination and Continuity of Care (90.0%), Availability of Services (95.1%), Provider Selection (95.2%), Assurances of Adequate Capacity and Services (97.9%), and Enrollee Rights and Protections (97.7%). In total, 739 elements were reviewed for compliance. Of those 739 elements, 708 were determined to fully meet the regulations, while 20 partially met the regulations, and 6 were determined to be non-compliant. Five elements were N/A. The overall compliance score for Magellan was 97.8% (**Table 6**).

Table 6: Audit Results by Audit Domain

CFR	Domain	Total Elements	Met	Partially Met	Not Met	N/A	Score[1]
438.206	Availability of Services	41	39	0	2	0	95.1%
438.207	Assurances of Adequate Capacity and Services	95	90	4	0	1	97.9%
438.208	Coordination and Continuity of Care	45	36	9	0	0	90.0%
438.210	Coverage and Authorization of Services – UM	69	69	0	0	0	100%
438.214	Provider Selection	95	87	5	2	1	95.2%
438.224	Enrollee Rights and Protection	144	140	2	2	0	97.9%
438.228	Grievance and Appeal Systems	74	74	0	0	0	100%
438.230	Subcontractual Relationships	10	10	0	0	0	100%
438.236	Practice Guidelines	8	8	0	0	0	100%
438.242	Health Information Services	10	10	0	0	0	100%
438.330	Quality Assessment & Performance Improvement	39	39	0	0	0	100%
438.608	Fraud, Waste and Abuse	109	106	0	0	3	100%
	Total	**739**	**708**	**20**	**6**	**5**	**97.8%**

[1] Each met element receives 1 point, each partially met element receives 1/2 point, and each not met element receives zero points. N/A elements are removed from the denominator. Score is equal to the sum of all points earned/applicable elements.
UM: utilization management

VI. Validation of Network Adequacy

Objectives

In the absence of a CMS protocol for *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, IPRO assessed MCO compliance with the standards of *Title 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 *Title 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 BH 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 BH 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 BH 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 BH outpatient non-MD services (excluding BH 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 BH 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 4/1/2022–6/30/2022. IPRO obtained the GeoAccess report from LDH for the evaluation included in this ATR.

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 2022, Magellan met GeoAccess standards for the Outpatient Service 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. EQRO's Assessment of 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** details the IPRO assessment determination levels. **Table 9** 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.

Table 8: IPRO Assessment Determination Levels

Assessment Determinations	Definitions
Addressed	MCO's QI response resulted in demonstrated improvement.
Partially Addressed	MCO's QI response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement	MCO's QI response did not address the recommendation; improvement was not observed, or performance declined.

MCO: managed care organization; QI: quality improvement.

Magellan Response to Previous EQR Recommendations

Magellan's responses to previous EQR recommendations are presented in **Table 9**.

Table 9: Magellan Response to Previous EQR Recommendations

Recommendation for Magellan	Magellan Responses/Actions Taken	IPRO Assessment of MCO Response[1]
Compliance with Medicaid and CHIP Managed Care Regulations **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	**Adequate Capacity and Service** Please see page 117 of the UM 02 QAPI Program Evaluation re: what was reported to the LDH for 2021. Additionally, we monitor reimbursement rates through quarterly Network Strategy and Utilization Management Committees. This includes, but is not limited to, increases in licensed professionals in the network, as well as increases in service utilization. In 2020, the CSoC Unit executed an EBP workbook initiative to support CPST masters-level workers implement evidence-based treatment modalities for anxiety, depression, and trauma. Topics included: **SOS Help for Parents (**evidence-based behavior therapy interventions to address a variety of common behavior problems) and **CBT Toolbox for Children and Adolescents** (designed to provide brief, targeted solutions to a myriad of mental health issues that are frequently present in children). The CSoC Unit distributed 452 workbooks to 226 Mental Health Rehabilitation agencies in July 2021. During that time, the WAAs also received training on how to utilize the workbooks with youth and families to support development of strategies that utilize EBP services and interventions. To assess effectiveness, POC Reviews completed between 1/1/2020 and 12/31/2021 were analyzed and 90.49% of plans considered the utilization of EBPs, when appropriate. **Grievances and Appeals**	Partially Addressed. This will be assessed during the next compliance review in 2022.

Recommendation for Magellan	Magellan Responses/Actions Taken	IPRO Assessment of MCO Response[1]
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.	The following interventions were completed by 10/30/2020: Magellan updated letter templates and conducted staff trainings. Magellan reviews 100% of all appeal files to ensure accuracy and timeliness. In IPRO's July 2022 audit, 10 grievance files were reviewed and found to be in full compliance with contract requirements. Also, the following verbiage was incorporated into Magellan's Provider Handbook supplement in 2021: Our Philosophy - To achieve a high level of member satisfaction and care, Magellan believes in providing a mechanism for providers and external agencies to express complaints related to care, service, confidentiality, policy, procedure, payment or any other communication or action by Magellan. **Our Policy** - Magellan maintains a Provider Complaint System for providers to dispute Magellan's policies, procedures, or any aspect of Magellan's administrative functions. Magellan defines a provider complaint as any verbal or written expression originating from a provider and delivered to any employee of Magellan that voices dissatisfaction with a policy, procedure, payment, or any other communication or action by Magellan. Please note member grievance and appeals filed by providers on behalf of a member are processed using our member grievance and appeals policies as outlined in this section. What You Need to Do - Follow procedures for escalating a complaint or contact LDH directly. This process is in place for both in-network and out-of-network providers to dispute Magellan's policies, procedures, or any aspect of Magellan's administrative functions. Additionally, you may file a complaint directly with LDH for any decision that is not unique to Magellan or if you feel you have exhausted Magellan's provider complaint system. The escalation procedures are also accessible via the Magellan of Louisiana website in the Issue Escalation and Resolution section.	

[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.
EQR: external quality review; MCO: managed care organization; CHIP: Children's Health Insurance Program; LDH: Louisiana Department of Health; ATR: annual technical report; UM: utilization management; QAPI: quality assurance and performance improvement; CSoC: Coordinated System of Care; WAA: wraparound agency; POC: plan of care.

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

Title 42 CFR §438.364(a)(4) states that EQR technical reports must include an assessment of strengths and weaknesses, as well as recommendations for each managed care entity. **Table 10** 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**.

Table 10: Magellan Strengths and Opportunities, and EQR Recommendations

Magellan EQR Activity	Description	Quality	Timeliness	Access
Strengths				
PIPs 1) Monitoring Hospitalization Follow-Up Practices	• ITM 1 (Wraparound Coordinator follow-up calls to member) increased from 20.0% Y2 Q3 to 26.67% Y3 Q2 and ITM 5 (Youth connection with MHP prior to inpatient stay) increased from 76.36% Y2 Q3 to 77.78% Y3 Q3; youth connection with MHP prior to inpatient stay was also reported by Magellan to be statistically associated with attendance at a follow-up appointment. • The highest ITM rates were observed for ITM 2 (POC), ITM 4 (FSO within 7 days) and ITM 5 (prior MH appointment).	X	X	X
Compliance with Medicaid and CHIP Managed Care Regulations	Magellan demonstrated full compliance in 7 of the 12 domains. Fully compliant domains include: Coverage and Authorization of Services, Grievance and Appeal Systems, Subcontractual Relationships, Practice Guidelines, Health Information Services, Quality Assessment & Performance Improvement, and Fraud, Waste and Abuse. The overall compliance score for Magellan was 97.8%.	X	X	X
Performance Measures	Five measures were selected for validation: 1. Follow-up After Hospitalization for Mental Illness (FUH01), 2. Number and percent of participants whose level of care determination form was completed timely as required by the state (LOC02), 3. Number and percent of participants whose plans of care were updated timely, as specified in the waiver application (POC04), 4. Number and percent of participants who received information on available HCBS, as documented by the participant/authorized representative's signature on the State approved form (POC08), and 5. Access to Wraparound (QM12). All five measures passed validation at 100%	X	X	X
Network Adequacy	In June 2022, Magellan met geographic access standards for the Outpatient Services reviewed for 100% of its Medicaid membership.	–	–	X

Magellan EQR Activity	Description	Quality	Timeliness	Access
Opportunities for Improvement				
PIPs	Magellan has requested an additional year to conduct this PIP in order to address the lack of improvement attributed to COVID-19 PHE challenges; however, it is not clear that missed opportunities for improvement did not influence the lack of progress. The Next Steps section was not completed and should address the Final Review comments with plans for next steps.	X	X	X
Compliance with Medicaid and CHIP Managed Care Regulations	Magellan demonstrated less than full compliance in 5 of the 12 domains. The domains not met in full include: Coordination and Continuity of Care (90.0%), Availability of Services (95.1%), Provider Selection (95.2%), Assurances of Adequate Capacity and Services (97.9%), and Enrollee Rights and Protections (97.7%).	X	X	X
Performance Measures	None identified	–	–	–
Network Adequacy	None identified	–	–	–
Network Adequacy	In June 2022, Magellan did not meet geographic access standards for the BH Specialists, Prescribers, and Psychiatrists reviewed for 100% of its Medicaid membership.	–	–	X
Recommendations				
PIPs	It is recommended that LDH's decision regarding Magellan's request to continue the PIP be based on the extent that the Next Steps address these comments and demonstrate a robust approach to interventions based on lessons learned. In addition, goals should be set higher as recommended in the review comments.	X	X	X
Compliance with Medicaid and CHIP Managed Care Regulations	For details of recommendations for Magellan for compliance elements that received a "Not Met" review determination refer to Appendix B.	X	X	X
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	X	–	X

Magellan EQR Activity	Description	Quality	Timeliness	Access
	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.			
Performance Measures	None identified	–	–	–
Network Adequacy	Magellan should work together with the BH Specialists, Prescribers, and Psychiatrists to improve network access.	–	–	**X**

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

IX. Appendix A Magellan Health Disparities

Table and figure references from Magellan's response to the question below regarding the period July 1, 2021–June 30, 2022:

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)?

Appendix: Tables and Figures

Figure 1. Referrals Received in Calendar Year 2021 by Quarter

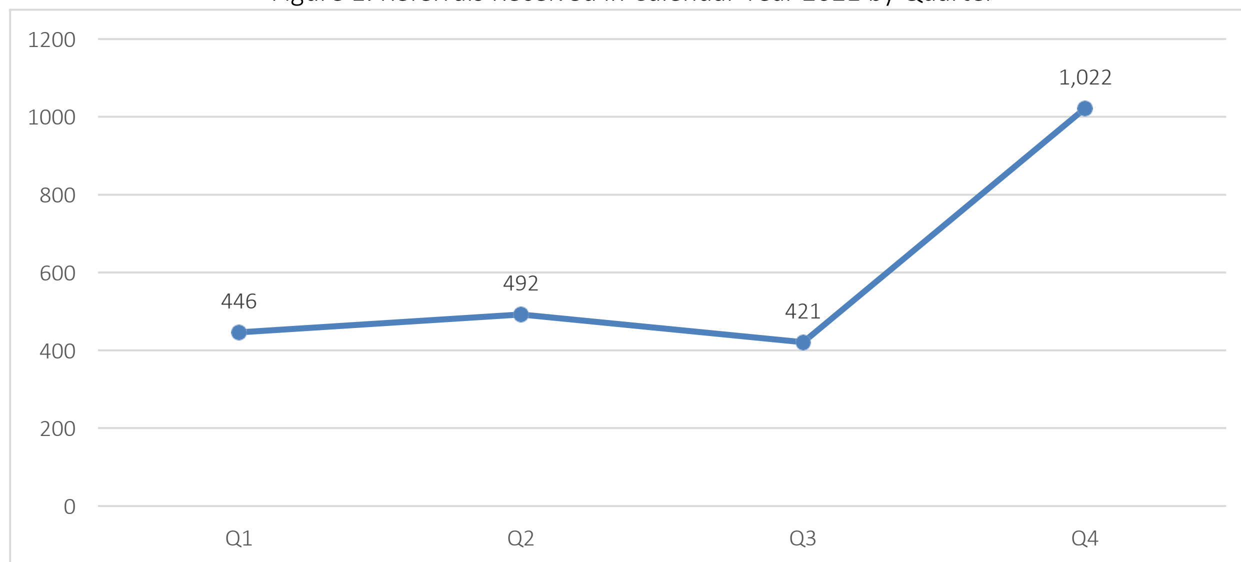


Table 1. Geographic Classification on Last Day of the Year

	2020		2021	
Member Group	Number	Percent	Number	Percent
Urban/Suburban	981	31.08%	948	27.18%
Rural	2,585	68.92%	2,604	71.56%
Unknown	91	2.49%	46	1.26%
Total	3,657*	100%	3,639	100%

* Please note that the total number of enrollments reported for 2020 (N = 3,657) in Table 1 is slightly different than the total number of enrollments reported for the remaining demographic categories (N = 3,529) in this section. The report was required to be rerun in 2022 to account for minor changes made to the reporting specifications. Differences in total number is expected for the data source (i.e., eligibility feed), which is updated daily.

Table 2. Gender of CSoC Members

	2020		2021	
Gender	Number	Percent	Number	Percent
Female	1,452	41.04%	1,511	41.25%
Male	2,077	58.96%	2,218	58.48%
Total	3,529		3,639	

Table 3. Race of CSoC Members

	2020		2021	
Race	Number	Percent	Number	Percent
Black/African American	1,948	55.20%	1,930	53.04%
White	1,407	39.87%	1,501	41.25%
Multi-Racial	58	1.64%	109	3.00%
Other/Single Race	53	1.50%	49	1.35%
American Indian/Alaskan Native	19	0.54%	25	0.69%
Native Hawaiian/Pac Islander	9	0.26%	10	0.27%
Asian	6	0.17%	3	0.08%
Unknown	29	0.82%	12	0.33%
Total	3,529		3,639	

Table 4. Ethnicity of CSoC Members

	2020		2021	
Ethnicity	Number	Percent	Number	Percent
Non-Hispanic/Non-Latino	3,403	96.43%	3,543	97.36%
Hispanic/Latino	88	2.49%	77	2.1%
Unknown	38	1.08%	19	0.52%
Total	3,529		3,639	

Figure 2. Social Determinants of Health – Risk Factors

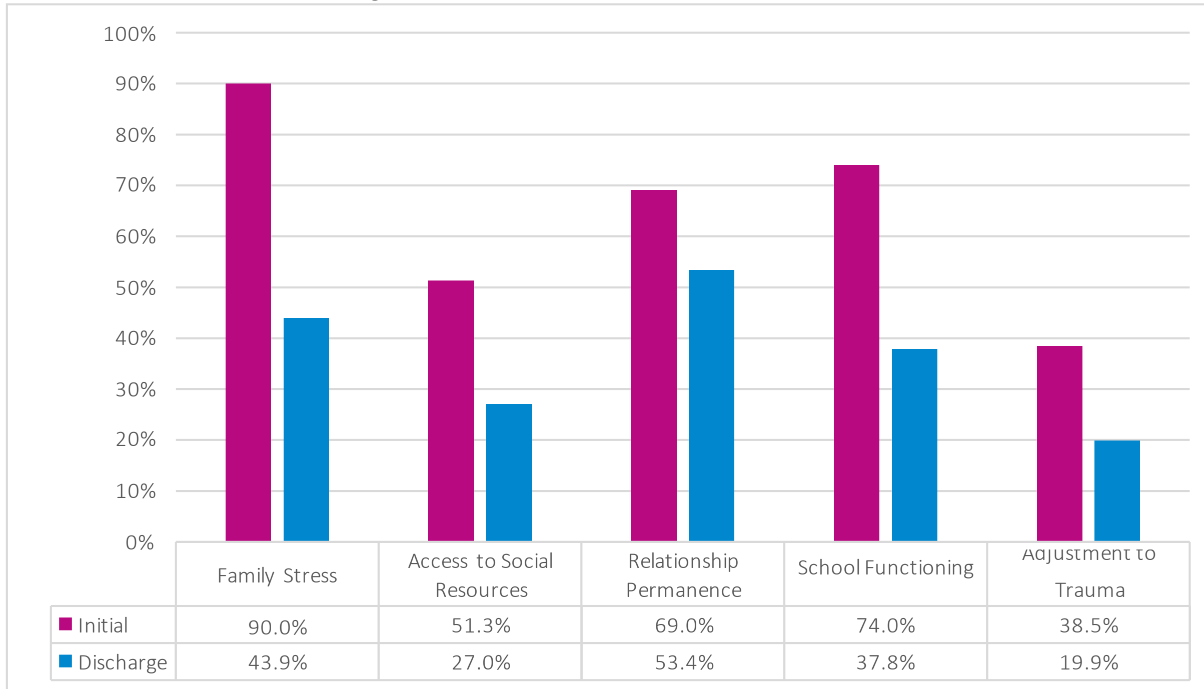


Figure 3. Social Determinants of Health – Protective Factors

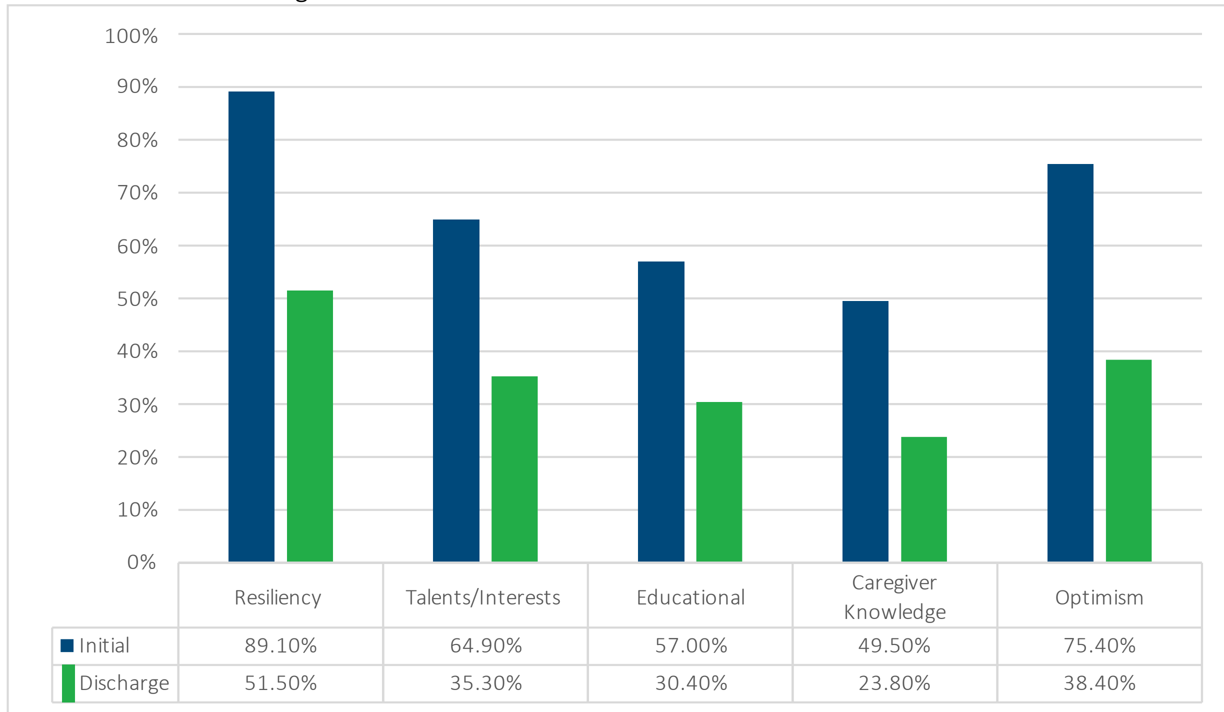
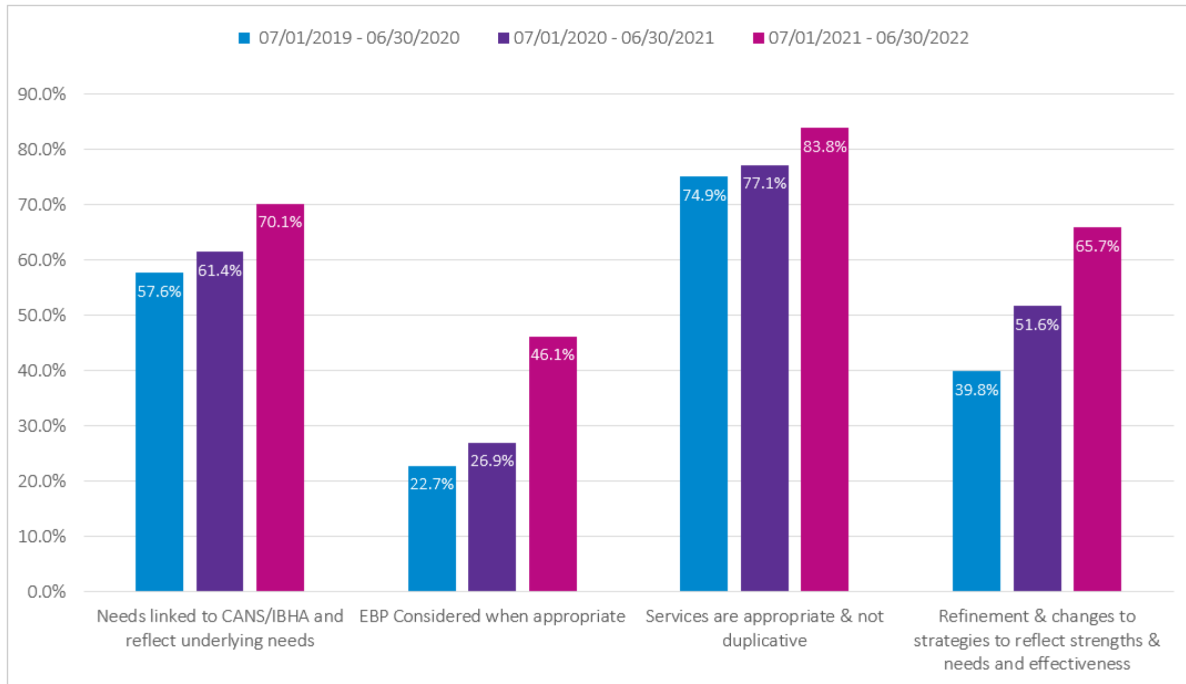


Table 5. Analysis of Disproportionate Under-Representation- 30-Day Follow-Up Hospitalization (FUH) Rate

Type	CSoC Profile	% of Profile	Respondents	% of Respondents	Disproportionate Index (% Profile/ % Respondents)	Proportionate Index (% Respondents/ % Profile)
Members	1,994	100%	330	100%		
Gender						
Female	827	40.42%	133	40.30%	100.29%	1.00
Male	1,219	59.58%	191	57.88%	102.94%	0.97
Unspecified	0	0.00%	6	1.82%	-	-
Race						
American Indian or Alaska Native	20	1.00%	2	0.61%	165.50%	0.60
Asian	3	0.15%	0	0.00%	-	-
Black or African American	1,110	55.67%	179	54.24%	102.63%	0.97
Native Hawaiian or Pacific Islander	7	0.35%	0	0.00%	-	-
Multi-Racial	44	2.21%	15	4.55%	-	-

Figure 4. QIA Results, 07/01/2019 – 06/30/2022



X. Appendix B Magellan Not Met Compliance Review Elements

LA Citation	State Contract Requirements	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
6.3.1.1.3	Requests for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.	Not Met		This requirement is not addressed in any policies or procedures. During the interview, Magellan indicated that they will Include this requirement in a future policy. Magellan also indicated that there were no requests requiring LDH approval during the review period. **<u>Recommendation</u>** The entity should include this requirement in a policy or procedure.	Magellan respectfully disagrees with IPRO's review determination. We believe that we Met this requirement. Magellan's Statement of Work with the LDH is the overarching policy governing all CSoC operations. We complied with this requirement throughout the review period but we have added this to CSoC Network Development and Management Plan_Final Version_04.01.2022, based on your recommendation. See comment on page 5	Magellan provided annotated version of the Network Development Plan indicating future versions of the document will address this requirement. No change in determination.
6.3.1.1.4	There shall be no penalty if the member chooses to travel further than established access standards in order to access a member's provider of choice. The member shall be responsible for travel arrangements and costs.	Not Met		This requirement is not addressed in any policies or procedures. During the interview, Magellan indicated that they will Include this requirement in a future policy. Magellan also indicated that there were no requests requiring LDH approval during the review period. **<u>Recommendation</u>** The entity should include	Magellan respectfully disagrees with IPRO's review determination. We believe that we Met this requirement. Magellan's Statement of Work with the LDH is the overarching policy governing all CSoC operations. We complied with this requirement throughout the review period but we have updated CSoC Network Development and Management Plan_Final	Magellan provided annotated version of the Network Development Plan indicating future versions of the document will address this requirement. No change in determination.

LA Citation	State Contract Requirements	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
				this requirement in a policy or procedure.	Version_04.01.2022, based on your recommendation. See comment on page 5	
6.7.3	The Contractor shall not delegate credentialing of providers.	Not Met		This requirement was addressed in Magellan's Provider Credentialing and Re-credentialing Activities Process Policy and Procedure. However, language meeting this requirement was incorporated into policy in 2022, after the January 1, 2021- December 31, 2021 review period. **Recommendation:** IPRO acknowledges that Magellan included this state contract requirement into policy following the January 1, 2021- December 31, 2021 review period. Therefore, no additional follow-up actions are recommended for future compliance.	Magellan respectfully disagrees with IPRO's review determination. We believe that we Met this requirement. Magellan's Statement of Work with the LDH is the overarching policy governing all CSoC operations. We complied with this requirement throughout the review period, but we have updated Provider Credentialing and Recredentialing Process 6.7xx policy based on your recommendation	**IPRO Final Findings:** Not enough evidence provided to overturn review determination.
6.7.5	The Credentialing Application Form and Re-Credentialing Application Form will be submitted to LDH for approval prior to contract implementation and at any time of a requested substantive change in content.	Not Met		This requirement was addressed in Magellan's Provider Credentialing and Re-credentialing Activities Process Policy and Procedure. However, language meeting this requirement was incorporated into policy in 2022, after the January 1, 2021- December 31, 2021 review period.	Magellan respectfully disagrees with IPRO's review determination. We believe that we Met this requirement. Magellan's Statement of Work with the LDH is the overarching policy governing all CSoC operations. We complied with this requirement throughout the review	**IPRO Final Findings**: Not enough evidence provided to overturn review determination.

LA Citation	State Contract Requirements	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
				Recommendation: IPRO acknowledges that Magellan included this state contract requirement into policy following the January 1, 2021- December 31, 2021 review period. Therefore, no additional follow-up actions are recommended for future compliance.	period, but we have updated Provider Credentialing and Recredentialing Process 6.7xx policy based on your recommendation	
5.6.1.6	All marketing activities should provide for equitable distribution of materials without bias toward or against any group.	Not Met		This requirement is not addressed in the Member Education plan. **Recommendation** The entity should incorporate the written materials requirements into a policy.	We met this requirement for the review period; please see the attached updated Member Education plan which includes additional verbiage to reflect this.	While the entity states that this requirement was met for the review period, it is unclear if the additional verbiage in the updated Member Education plan (provided upon follow up) was incorporated during the 2021 review period. Determination changed to partially met.
5.6.1.3	All written materials must be clearly legible with a minimum font size of twelve-point, unless otherwise approved by LDH or required by 42 CFR §438.10.	Not Met		This requirement is not addressed in the Member Education plan. **Recommendation** The entity should incorporate the written materials requirements into a policy.	We met this requirement for the review period; please see the attached updated Member Education plan which includes additional verbiage to reflect this.	While the entity states that this requirement was met for the review period, it is unclear if the additional verbiage in the updated Member Education plan (provided upon follow up) was incorporated during the 2021 review period. Determination changed to partially met.