LOUISIANA DEPARTMENT OF HEALTH

State Fiscal Year July 1, 2023–June 30, 2024

External Quality Review Technical Report

for

Magellan of Louisiana

February 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgments and Copyrights

1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) (collectively referred to as "managed care entities [MCEs]" in this report) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality, timeliness, and accessibility of services provided by the contracted MCEs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1-1] with further revisions released in November 2020.[1-2] The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Louisiana Department of Health (LDH) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

The Louisiana Medicaid Managed Care Program

The day-to-day operations of the Louisiana Medicaid managed care program are the responsibility of the Bureau of Health Services Financing within LDH, with oversight of specialized behavioral health services, 1115 Substance Use Demonstration Waiver, and the Coordinated System of Care Waiver provided by the Office of Behavioral Health (OBH). In addition, the Bureau of Health Services Financing receives support from other LDH "program offices"—Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), and Office for Citizens with Developmental Disabilities (OCDD). Louisiana Medicaid managed care provides services to over 1.8 million Louisianans, which is approximately 39 percent of the State's population.

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral healthcare and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a 1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 12, 2024.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 12, 2024.

health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2023 (July 1, 2023–June 30, 2024) are displayed in Table 1-1. Of note, no MCEs are exempt from EQR.

Table 1-1—Louisiana's Medicaid MCEs

MCE Name	Plan Type	Services Provided	Service Region	Acronym or Abbreviated Reference
Aetna Better Health	MCO	Behavioral and physical health	Statewide	ABH
AmeriHealth Caritas Louisiana	MCO	Behavioral and physical health	Statewide	ACLA
Healthy Blue	MCO	Behavioral and physical health	Statewide	HBL
Humana Healthy Horizons	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA
Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS EQR Protocols released in February 2023.[1-3] For the SFY 2024 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about the quality, timeliness, and accessibility of healthcare services provided by the PIHP. Table 1-2 depicts the EQR activities conducted for each plan type.

Table 1-2—EQR Activities Conducted for Each Plan Type

EQR Activities	Description	Protocol	MCO	PAHP	PIHP
Performance Improvement Project (PIP) Validation	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting and, whether the PIP demonstrated significant improvement in performance.	Protocol 1. Validation of Performance Improvement Projects	✓	✓	✓
Performance Evaluation and Improvement	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures	✓	✓	✓
Compliance Reviews (CRs)	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations	✓	✓	✓
Network Adequacy and Availability Validation (NAV)	The audit activity assesses the accuracy of the state-defined network adequacy indicators reported by the MCEs; evaluates the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used; and determines the overall phases of design, data collection, analysis, and interpretation of the network	Protocol 4. Validation of Network Adequacy	✓	✓	✓

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 12, 2024.

EQR Activities	Description	Protocol	MCO	PAHP	PIHP
	adequacy indicators, as set forth by the State. Additionally, this activity evaluates the accuracy of provider directory information submitted by the MCOs and determines appointment availability information by conducting telephone surveys among a sample of providers.				
Consumer Surveys: CAHPS-A and CAHPS-C	This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Behavioral Health Member Satisfaction Survey	This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Health Disparities Focus Study	This activity uses data collected from the five MCOs to identify health disparities based on race, ethnicity, and geography, where applicable, at the statewide and MCO levels.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management services to determine the number of individuals, the types of conditions, and the impact that case management services have on members receiving those services.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
Quality Rating System (QRS)	This activity evaluates and applies a rating to measure the quality of care and performance of the MCOs to provide information to help eligible members choose an MCO.	Protocol 10. Assist with Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs	✓		

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2024. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

- Identify areas for quality improvement (QI).
- Ensure alignment among an MCE's Quality Assessment and Performance Improvement (QAPI) requirements, the State's quality strategy, and the annual EQR activities.
- Purchase high-value care.
- Achieve a higher performance healthcare delivery system for Medicaid and CHIP beneficiaries.
- Improve the State's ability to oversee and manage the MCEs with which it contracts for services.
- Help the MCEs improve their performance with respect to the quality, timeliness, and accessibility of care.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of each Louisiana Medicaid MCE in each of the domains of quality, timeliness, and access.

Quality	Timeliness	Access
as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]	as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

Methodologies

Requirement 42 CFR §438.364(a)(1) describes the manner in which (1) the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and (2) conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the PIHP.

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by the PIHP, as well as the program overall. To produce the PIHP's SFY 2024 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the PIHP:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for the PIHP to identify strengths and opportunities for improvement in each domain of quality, timeliness, and access to services furnished by the PIHP for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and access to care and services furnished by the PIHP.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of quality, timeliness, and access to care and services furnished by the PIHP.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Louisiana's Medicaid Managed Care Quality Strategy

In accordance with 42 CFR §438.340, LDH implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Louisiana Medicaid members under the Louisiana Medicaid managed care program. Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated September 2023 is guided by the Triple Aim of the National Quality Strategy.

LDH's mission is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for citizens of the state of Louisiana. The Medicaid managed care program in Louisiana is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid members.

Goals and Objectives

The quality strategy identified goals and objectives that focus on process as well as achieving outcomes. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Louisiana Medicaid managed care program.

The quality strategy identifies the following three aims and eight associated goals:

Better Care: Make healthcare more person-centered, coordinated, and accessible so it occurs at the "Right care, right time, right place."

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

Goal 3: Facilitate patient-centered, whole-person care

Healthier People, Healthier Communities: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

Goal 6: Partner with communities to improve population health and address health disparities

Smarter Spending: Demonstrate good stewardship of public resources by ensuring high-value, efficient care.

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

Overall, the quality strategy serves to effectively measure and improve the quality of Louisiana's Medicaid managed care services. LDH's initiatives tie to the quality strategy aims, goals, and objectives. The quality strategy also promotes identification and implementation of initiatives to monitor, assess, and improve access to care, quality of care, and timeliness of service delivery for Louisiana Medicaid members. LDH plans to incorporate goals from the National Quality Strategy in the quality strategy in

[1-4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Dec 12, 2024.

the future. LDH oversees the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. LDH has an MCO contract requirement that the MCO should be committed to QI. Each MCO is required to be NCQA accredited and to conduct HEDIS performance measure reporting. LDH plans to also include the requirement for a commitment to QI in the PAHP contract.

Recommendations

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH identify a measure to align with the following objectives:
  - Ensure appropriate hospice onboarding and transitioning from palliative care to hospice.
  - Promote early initiation of palliative care to improve quality of life.
  - Promote health development and wellness in children and adolescents.
  - Advance specific interventions to address social determinants of health.
  - Advance value-based payment arrangements and innovation.
  - Ensure members who are improving or stabilized in hospice are considered for discharge.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends LDH include performance measures for the PAHPs and PIHP in the quality strategy.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH continue to work with the MCEs during PIP and Medicaid Advisory Committee (MAC) meetings to discuss best practices for performance measures. During these discussions, LDH could focus on specific performance measures in the quality strategy that have not met improvement objectives and target objectives.
- To improve MCO performance in Goal 6, "Partner with communities to improve population health and address health disparities," HSAG recommends that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans and the progress being made through quality interventions to reduce health disparities.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends LDH assess MCO failure to provide non-emergency medical transportation (NEMT) and have the MCOs implement interventions to improve provision of NEMT and ensure it is timely and accessible.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH assess areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty. This assessment should identify root causes for noncompliance and then work to identify appropriate interventions to eliminate noncompliance and improve performance.

- HSAG recommends that LDH report rates for the following measures:
  - Enrollment by Product Line
  - Language Diversity of Membership
  - Race/Ethnicity Diversity of Membership

Actions on External Quality Review Recommendations

The EQRO identified the following recommendations for the quality strategy during SFY 2022–2023. These recommendations included how LDH could target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 includes the recommendations that the EQRO made to LDH to support program improvement and progress in meeting the goals of the quality strategy. The State's responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Table 1-3—SFY 2022–2023 EQRO Recommendations and LDH Actions

SFY 2022–2023 EQRO Recommendations	LDH Actions
HSAG recommended LDH consider a change in metric benchmarks so the MCEs can strive toward a consistent performance level. HSAG recommended LDH remove the target objectives and improvement objectives and establish benchmarks for all MCEs that align with nationally recognized quality measures (e.g., NCQA Quality Compass,[1-5] CMS Adult and Child Core Sets) or the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.	LDH declined to change the target objectives and improvement objectives.
HSAG recommended LDH consider using the measurement year (MY) 2023 reported rates in the 2024 quality strategy evaluation, which could include MY 2021 through MY 2023 results in order to include the most current data for evaluation.	LDH agreed to use the MY 2023 reported rates in the 2024 quality strategy evaluation.
HSAG recommended LDH remove the duplicate objective, promote healthy development and wellness in children and adolescents.	LDH updated the quality strategy to remove this duplicate objective.
HSAG recommended LDH consider adding the objectives, improve overall health and promote reproductive health objectives, to the quality strategy.	LDH updated the quality strategy to include these two objectives.
HSAG recommended LDH continue to collaborate with the MCOs to support adequate QI capacity, skills, and resources to support current and future PIPs. HSAG recommended LDH continue to meet regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could	LDH will continue to meet and collaborate with the MCOs related to PIPs. LDH agreed with the EQRO's recommendation to incorporate a similar PIP collaboration process for

[1-5] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

SFY 2022–2023 EQRO Recommendations	LDH Actions
consider incorporating a similar mechanism for the PAHPs to collaborate on current and future PIPs. HSAG also recommended LDH consider hosting a forum in which the MCEs could discuss programwide solutions to overcome barriers. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.	the PAHPs, and the process is currently being developed. Lastly, LDH considers the monthly PIP meetings to be an avenue for discussing programwide solutions to overcome barriers.
HSAG recommended LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.	LDH declined to change the improvement targets' time period.
HSAG recommended the MCEs consider whether there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommended the MCEs target QI interventions to reduce the identified disparities.	The MCOs document this process in their annual health equity plans.
HSAG recommended LDH consider working with the MCEs to share performance measure best practices and identify interdependencies across measures.	LDH currently works with the MCEs collaboratively during monthly and quarterly PIP meetings as well as quarterly MAC meetings. The MAC consists of MCE chief medical officers (CMOs). Best practices are discussed frequently. In addition, LDH meets with the MCO chief executive officers (CEOs) and other support staff during quarterly business reviews to discuss recommendations and best practices.
HSAG recommended LDH consider a contract statement for all MCEs that the MCEs' quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.	LDH plans to add a similar statement to the dental contract. Quality is being revamped and expanded for dental. LA Medicaid will also work with OBH to incorporate in the CSoC contracts.
HSAG recommended LDH consider removing Aim statements from the quality strategy. CMS defines "quality strategy goals" as SMART (specific, measurable, attainable, relevant, and time-bound), high-level managed care performance aims that provide direction for the State. CMS defines "quality strategy (SMART) objectives" as measurable steps toward meeting the State's goals that typically include quality measures.	LDH plans to move to incorporate the CMS National Quality Strategy to encompass the four National Quality Strategy priority areas.

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for Magellan of Louisiana (Magellan), the PIHP, conducted with Louisiana Medicaid managed care throughout SFY 2024.

Validation of Performance Improvement Projects

For the SFY 2024 PIP validation, the PIHP submitted for validation the design and implementation of a PIP focused on the quality of wraparound care plans and use of evidence-based practices in wraparound care plans for youth in the eligible population. Magellan progressed to reporting baseline performance indicator results and initial interventions for the PIP during the second validation cycle in SFY 2024. HSAG assigned the PIHP's PIP submission a validation rating of *High Confidence* for adhering to an acceptable methodology for all phases of the PIP (steps 1 through 8 of the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 [CMS EQR Protocol 1]).[1-6] The PIHP will progress to the Outcomes stage of the PIP for validation in SFY 2025.

Validation of Performance Measures

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

Five measures in the area of quality management were selected for validation, and all five measures received a *Reportable* validation designation, as the PIHP calculated the measures in compliance with the specifications:

- *Follow-Up After Hospitalization for Mental Illness*
- *Child and Adolescent Needs and Strengths (CANS) Outcomes*
- *Living Situation at Discharge*
- *Improved School Functioning*
- *Utilization of Natural Supports*

All five measures were included in the validation scope for this year and the previous year, and HSAG could compare the PIHP's performance across the years for most measures. For the *Follow-Up After Hospitalization for Mental Illness* measure, the PIHP used modified HEDIS specifications in prior years

[1-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 12, 2024.

but followed HEDIS specifications to calculate this year's rates. As a result, HSAG cannot compare this year's rates on the *Follow-Up After Hospitalization for Mental Illness* measure to rates reported by the PIHP in prior years.

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG reviewed the corrective action plans (CAPs) that Magellan prepared to remediate any deficiencies identified during the 2023 CR. HSAG and LDH evaluated the sufficiency of the CAPs. Magellan achieved compliance in three of three elements from the 2023 CAPs. Magellan demonstrated that it successfully remediated all three elements, indicating the necessary initiatives were implemented and demonstrated compliance with the requirements under review.

HSAG will conduct a comprehensive CR during 2025 to determine the extent to which the MCOs are in compliance with federal standards during the review period CY 2024.

Validation of Network Adequacy

HSAG identified no network adequacy indicators in scope of review received a *No Confidence* or *Low Confidence* validation rating determination.

HSAG determined that Magellan was compliant with network adequacy requirements for all but three provider types. LDH required a 100 percent threshold for Magellan when determining compliance with distance standards. Results that achieved the 100 percent threshold are shaded in green. Table 1-4 contains the percentage of members Magellan reported with access by provider type and by urbanicity.

Table 1-4—Magellan Distance Requirements: Percentage of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity With Indicator	Percentage of Members With Access
Psychiatrists	Urban (15 miles)	99.8%
	Rural (30 miles)	80.9%
Behavioral Health Specialists (psychologists, medical psychologists, advanced practice registered nurses [APRNs] or clinical nurse specialists [CNSs], or licensed clinical social workers [LCSWs])	Urban (15 miles)	100%
	Rural (30 miles)	94.5%
Specialized Behavioral Health Outpatient Non-Medical Doctor (MD) Services (excluding behavioral health specialists)	Urban (60 miles)	100%
	Rural (90 miles)	100%

HSAG assessed Magellan's results for behavioral health providers and determined that Magellan met all LDH-established performance goals for appointment access standards. Table 1-5 displays the indicator and achieved compliance rate.

Table 1-5—Magellan Appointment Access Standards Compliance Rate for Behavioral Health

Indicator	Reported Compliance Rate
Emergent care 24 hours per day, 7 days per week, within 1 hour of request.	100%
Urgent care 24 hours per day, 7 days per week, within 48 hours of request.	100%
Routine, non-urgent behavioral healthcare shall be available with an appointment within 14 days of request.	100%

2. Validation of Performance Improvement Projects

Results

SFY 2024 was the second year that HSAG validated Magellan's PIP as part of the EQRO contract with LDH. The PIHP continued a PIP focused on improving the use of evidence-based wraparound care planning for enrollees. The CY 2023 (review period) validation results for Magellan's PIP are summarized in Table 2-1.

Table 2-1—SFY 2024 PIP Topic, Performance Indicator, and Targeted Age Group for Magellan

PIP Topic	Performance Indicators	Targeted Age Group
Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team	*Evidence-based practices (EBPs) are considered when appropriate*	Not applicable
	Refinement and changes to strategies to reflect strengths, needs, and plan effectiveness	

Validation Results and Confidence Ratings

Table 2-2 summarizes the SFY 2024 PIP performance for the PIHP. The PIHP conducted a PIP focusing on improving the use of evidence-based wraparound care planning for enrollees.

Table 2-2—SFY 2024 PIP Validation Results for Magellan

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

For the SFY 2024 PIP validation, Magellan received *High Confidence* for Validation Rating 1. The PIHP received *Met* scores for 100 percent of applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool, demonstrating strength in adhering to acceptable methodologies for selecting the PIP topic and developing the Aim statement, population definition, performance indicator definitions, sampling methods, data collection, analysis of indicator results, and initial improvement strategies through the baseline measurement period. For Validation Rating 2, which is based on scores in Step 9 of the PIP Validation Tool, Magellan's PIP was *Not Assessed* for this year's validation. The PIP will be assessed for Validation Rating 2 when Magellan progresses to reporting remeasurement results for the performance indicators and evaluating whether improvement over baseline was demonstrated. In SFY 2025, Magellan will progress to reporting Remeasurement 1 indicator results and improvement strategies, and HSAG will validate the PIP through Step 9. The SFY 2025 PIP validation findings, Remeasurement 1 indicator results, and improvement strategies will be included in next year's EQR technical report.

Performance Indicator Results

Table 2-3 displays performance indicator data from completed measurement periods for Magellan's *Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team* PIP.

Table 2-3—Performance Indicator Results for the *Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
EBPs are considered when appropriate	N: 682 D: 1,864	36.6%					*Not Assessed*
Refinement and changes to strategies to reflect strengths, needs, and plan effectiveness	N: 580 D: 1,242	46.7%					*Not Assessed*

Interventions

Table 2-4 summarizes the barriers Magellan identified for the PIP and the interventions carried out to address each barrier. Based on HSAG's validation findings, Magellan used a methodologically sound approach to identify barriers and develop interventions. HSAG concluded that the interventions carried out for Magellan's PIP could reasonably be expected to address identified barriers and had the potential to support improved performance indicator outcomes.

Table 2-4—Barriers and Interventions Reported by Magellan for the *Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team* PIP

Barriers	Interventions
• Inconsistent documentation and poor integration of strengths in plans of care (POCs) • Inconsistent POC scoring by reviewers • Limited EBP service providers in the CSoC program	• Reconfiguration of POC documentation platform, distribution of the updated platform across all regions, and comprehensive staff training on the updated platform • Revised POC review tool to provide clearer definitions and scoring criteria; staff training on the revised tool

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- The PIHP developed and carried out a methodologically sound design for the PIP that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The PIHP conducted robust barrier analyses to identify and prioritize barriers to improvement and initiated interventions that had the potential to address identified barriers and improve performance indicator results. **[Quality]**

Magellan received *Met* scores for 100 percent of applicable evaluation elements for the SFY 2024 PIP validation; therefore, HSAG did not identify any opportunities for improvement or recommendations.

Methodology

Requirement 42 CFR §438.364(a)(1) describes the manner in which (1) the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and (2) conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the PIHP.

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving PIHP processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the PIHP's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

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

The goal of HSAG's PIP validation is to ensure that LDH and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the QI strategies and activities the PIHP conducted during the PIP. HSAG's scoring methodology evaluated whether the PIHP executed a methodologically sound PIP.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[2-1]

HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the PIHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 12, 2024.

methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the PIHP improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the PIHP with specific feedback and recommendations. The PIHP used a standardized PIP Submission Form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP Submission Form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

In alignment with the CMS EQR Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the PIHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of services furnished by the PIHP. HSAG then identified common themes and the salient patterns that emerged across the PIHP related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed the CMS EQR Protocol 1 requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the project results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the PIHP, HSAG assigned the PIP topic to one or more of these three domains. While the focus of PIHP's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the PIHP's process for conducting a valid PIP. Therefore, HSAG assigned the PIP to the quality domain. In addition, the PIP topic was assigned to other domains as appropriate. This assignment to domains is shown in Table 2-5.

Table 2-5—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Topic	Quality	Timeliness	Access
Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team	✓	✓	✓

3. Validation of Performance Measures

Results

LDH OBH selects a set of quality report measures to evaluate the quality of care delivered by Magellan for its CSoC members. In 2024 (review period), OBH required Magellan to report a total of 49 measures across different areas of focus, including care management, utilization management, grievance and appeals, and quality management. Of these measures, OBH selected five quality management performance measures to be validated by HSAG.

Information Systems Capabilities Assessment

The PIHP was required to submit a completed Information Systems Capabilities Assessment Tool (ISCAT) that provided information on the PIHP's information systems (IS); processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

Based on HSAG's review of the ISCAT and evaluation of Magellan's data systems for the processing of each type of data used for reporting the five measures, no concerns were identified as it relates to the PIHP's eligibility and enrollment data system, administrative data system (claims and encounters), and data integration and rate production.

Performance Measures

A review of data by HSAG 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 HSAG's validation and received a *Reportable* designation.

Table 3-1 reflects the five performance measures and the associated measure types, designations, and reporting periods.

Table 3-1—Validated Measures

Performance Measure	Type of Measure	Measure Designation	Reporting Period
Follow-Up After Hospitalization for Mental Illness—7-Day	HEDIS	*R*	January 1, 2023–December 31, 2023
Follow-Up After Hospitalization for Mental Illness—30-Day			
CANS Outcomes	LDH	*R*	July 1, 2023–June 30, 2024

Performance Measure	Type of Measure	Measure Designation	Reporting Period
Living Situation at Discharge	LDH	*R*	July 1, 2023–June 30, 2024
Improved School Functioning	LDH	*R*	July 1, 2023–June 30, 2024
Utilization of Natural Supports	LDH	*R*	July 1, 2023–June 30, 2024

The final reported rates for the five measures validated are listed below.

Follow-Up After Hospitalization for Mental Illness

This HEDIS measure assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients ages 6 years and older that resulted in follow-up care with a mental health provider within seven and 30 days.

Table 3-2—Follow-Up After Hospitalization for Mental Illness Measure Results

Reporting Year	7-Day	30-Day
MY 2021	46.81%	66.67%
MY 2022	69.78%	82.50%
MY 2023*	38.24%	55.61%

*The PIHP calculated MY 2023 rates on the *Follow-Up After Hospitalization for Mental Illness* measure based on HEDIS specifications but used modified HEDIS specifications to calculate rates for prior years. HSAG cannot compare MY 2023 rates on this measure to prior years' rates.

CANS Outcomes[3-1]

This measure assesses the ability of CSoC to improve youths' clinical functioning.

Table 3-3—CANS Outcomes Measure Results

Indicator	CY 2023				CY 2024			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of youth who have been enrolled for at least 90 days who are discharging with valid change scores	90.67%	95.69%	95.93%	93.86%	91.05%	96.30%	98.20%	99.20%

[3-1] CANS is a multi-purpose standardized tool developed to support decision making, including level of care and service planning, to facilitate QI initiatives and to allow for the monitoring of outcomes of services.

Indicator	CY 2023				CY 2024			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of youth showing improved clinical functioning in CSoC	68.29%	65.59%	65.52%	71.34%	69.65%	65.80%	57.20%	59.10%

Corresponding CY—Quarter 1 = July 1–September 30; Quarter 2 = October 1–December 31; Quarter 3 = January 1–March 31; Quarter 4 = April 1–June 30

The percentage of eligible youth showing improved clinical functioning declined steadily from Quarter 1 to Quarter 3 during CY 2024 and rebounded slightly in Quarter 4. Compared to the previous reporting period, the percentage of eligible youth with improved clinical functioning notably declined in Quarter 3 and Quarter 4 of CY 2024.

Living Situation at Discharge

This measure assesses the ability of CSoC to maintain youth in the home and community and avoid out-of-home placement.

Table 3-4—Living Situation at Discharge Measure Results

Indicator	CY 2023				CY 2024			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of youth who have been enrolled for at least 90 days who are discharging with valid data on "living situation at discharge"	100%	100%	99.49%	100%	98.00%	99.31%	98.12%	99.54%
Percentage of youth discharging into a home and community-based (HCB) setting	93.95%	94.44%	93.86%	92.38%	97.50%	96.50%	95.50%	94.00%
Percentage of youth discharging to family home	91.32%	93.21%	90.28%	90.32%	95.50%	95.10%	94.50%	92.60%
Percentage of youth discharging to foster care	2.63%	1.23%	3.58%	2.05%	2.00%	1.40%	1.10%	1.40%

Indicator	CY 2023				CY 2024			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of youth discharging to inpatient hospital	0.00%	0.62%	1.28%	0.59%	0.10%	0.20%	0.00%	0.20%
Percentage of youth discharging to residential placement	4.21%	3.70%	2.30%	4.99%	1.30%	2.10%	2.30%	4.70%
Percentage of youth discharging to juvenile justice setting	1.32%	1.23%	2.05%	0.88%	1.00%	1.20%	1.90%	1.20%
Percentage of youth discharging to other setting	0.53%	0.00%	0.51%	1.17%	0.00%	0.00%	0.20%	0.00%

Corresponding CY—Quarter 1 = July 1–September 30; Quarter 2 = October 1–December 31; Quarter 3 = January 1–March 31; Quarter 4 = April 1–June 30

Over 90 percent of eligible youth were discharged to an HCB setting or a family home during CY 2024, as was the case during the previous reporting period. During both CY 2023 and CY 2024, there was a notable increase in the percentage of eligible youth discharged to residential placement between Quarter 3 and Quarter 4.

Improved School Functioning

This measure assesses the ability of CSoC to improve youths' school functioning measured by the percentage of youth showing improved school functioning (intake to discharge) on the CANS school module.

Table 3-5—Improved School Functioning Measure Results

Indicator	CY 2023				CY 2024			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CANS compliance rate	91.05%	95.69%	92.62%	93.86%	70.5%	83.8%	98.2%	99.2%
Percentage of children showing improved school functioning in CSoC	59.57%	56.42%	62.90%	60.47%	58.4%	66.5%	59.4%	52.8%
Percentage of children with improved school attendance	52.45%	53.78%	53.64%	56.39%	51.9%	64.9%	51.9%	47.7%

Indicator	CY 2023				CY 2024			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of children with improved school behavior	59.21%	53.57%	58.89%	55.92%	52.3%	62.6%	57.6%	47.3%

Corresponding CY—Quarter 1 = July 1–September 30; Quarter 2 = October 1–December 31; Quarter 3 = January 1-March 31; Quarter 4 = April 1–June 30

During CY 2024, there was a notable increase in the percentage of eligible youth that showed improved school functioning, improved school attendance, and improved school behavior in Quarter 2, and a notable decline in each of these performance categories in Quarter 4. Compared to the previous reporting period, performance across these categories declined in all quarters except for Quarter 2 in CY 2024.

Utilization of Natural Supports

The goal of this measure is to ensure wraparound care planning is helping families build sustainable teams with natural supports.

Table 3-6—Utilization of Natural Supports Measure Results

Percentage of Enrollees With at Least One Natural/Informal Support on the POC	CY 2023				CY 2024			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
All members	89.62%	87.71%	88.38%	88.69%	89.66%	93.0%	93.5%	90.8%
Members enrolled 0–90 days	80.40%	79.18%	82.64%	82.24%	80.60%	86.2%	88.8%	82.0%
Members enrolled 91–180 days	89.65%	84.96%	82.35%	85.39%	89.66%	90.1%	91.6%	87.4%
Members enrolled 181–360 days	90.31%	90.25%	91.49%	90.96%	89.90%	95.0%	96.0%	93.7%
Members enrolled 361–540 days	92.53%	91.30%	92.95%	92.41%	93.50%	97.4%	98.1%	97.1%
Members enrolled 541+ days	92.08%	91.43%	91.61%	90.78%	92.07%	97.4%	95.1%	96.0%

Corresponding CY—Quarter 1 = July 1–September 30; Quarter 2 = October 1–December 31; Quarter 3 = January 1–March 31; Quarter 4 = April 1–June 30

Compared to the previous reporting period, the percentage of all enrolled members with at least one natural support in the POC increased slightly across all four quarters in CY 2024.

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- During CY 2023 and CY 2024, the PIHP ensured that most eligible youth enrolled in the CSoC program avoided out-of-home placement and received needed services in an HCB setting or a family home. Over 90 percent of eligible youth were discharged to an HCB setting or a family home during CY 2024, as well as during the previous reporting period. **[Quality and Access]**
- During CY 2024, a greater percentage of eligible youth enrolled in the CSoC program demonstrated improved school functioning in Quarter 2 compared to the previous reporting period. Data reported by the PIHP for Quarter 2 showed an increase in the percentage of youth that improved school functioning, school attendance, and school behavior. **[Quality and Access]**

For Magellan, the following opportunities for improvement were identified:

- Compared to the previous reporting period, the percentage of eligible youth enrolled in the CSoC program with improved clinical functioning notably declined in Quarter 3 and Quarter 4 of CY 2024. **[Quality and Access]**
- During both CY 2023 and CY 2024, there was a notable increase in the percentage of eligible youth enrolled in the CSoC program that were discharged to residential placement between Quarter 3 and Quarter 4. **[Quality and Access]**
- During CY 2024, there was a notable decline in the percentage of eligible youth enrolled in the CSoC program that showed improvement in school functioning, school attendance, and school behavior between Quarter 3 and Quarter 4. **[Quality and Access]**

For Magellan, the following recommendations were identified:

- The PIHP's performance on several quality management measures declined between the third and fourth reporting quarters during CY 2024 and, at times, during the previous reporting period. HSAG recommended the PIHP review this observed trend in its reporting and identify the factors that hinder some CSoC members from improving clinical functioning and/or school performance during Quarter 4, as well as factors that resulted in more CSoC members being discharged to residential placement in Quarter 4. **[Quality and Access]**

Methodology

Objectives

In accordance with 42 CFR §438.330(c), states must require PIHPs to submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory EQR activities that the state Medicaid agencies are required to perform according to the Medicaid managed care regulations.

The primary objectives of the performance measure validation (PMV) process were to:

1. Evaluate the accuracy of performance measure data collected by the PIHP.
2. Determine the extent to which the specific performance measures calculated by the PIHP (or on behalf of the PIHP) followed the specifications established for each performance measure.
3. Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 2),[3-2] identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **ISCAT**—The PIHP was required to submit a completed ISCAT that provided information on the PIHP's IS; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—If the PIHP calculated the performance measures using computer programming language, it was required to submit source code for each performance measure being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the performance measure specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). If the PIHP did not use computer programming language to calculate the performance measures, it was required to submit documentation describing the actions taken to calculate each measure.

[3-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 12, 2024.

- **Performance measure reports**—HSAG also reviewed the PIHP's CY 2023 performance measure reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHP submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included a measure-level detail file provided for each measure for data verification.

Description of Data Obtained

As identified in the CMS EQR Protocol 2, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **ISCAT—**HSAG received this tool from the PIHP. The completed ISCAT provided HSAG with background information on the PIHP's policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from the PIHP (if applicable). If the PIHP did not produce source code to generate the performance indicators, the PIHP submitted a description of the steps taken for measure calculation from the point that the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the measure specifications.
- **Supporting Documentation—**This documentation provided additional information needed by HSAG reviewers to complete the validation process. Documentation included performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results—**HSAG obtained the calculated results from LDH and the PIHP.
- **Virtual On-Site Interviews and Demonstrations—**HSAG also obtained information through interaction, discussion, and formal interviews with key PIHP and LDH staff members as well as through virtual on-site systems demonstrations.

How Data Were Aggregated and Analyzed

HSAG performed a PMV audit of the PIHP for LDH's selected measures. HSAG evaluated the PIHP's eligibility and enrollment data systems, medical services data systems, and data integration process through an ISCAT, source code review, virtual review of the PIHP, and primary source verification (PSV) of a selected sample of measure data.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that the PIHP provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. HSAG further analyzed the quantitative results (e.g., performance measure results compared to benchmarks) and qualitative results (e.g., data collection and reporting processes) to identify strengths and opportunities for improvement and determine whether each strength and opportunity for improvement impacted one or more of the domains of quality, timeliness, or access. Additionally, for each opportunity for improvement, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PIHP's Medicaid members.

Additionally, to draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid PIHP, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-7.

Table 3-7—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
CANS Outcomes	✓		✓
Living Situation at Discharge	✓		
Improved School Functioning	✓		✓
Utilization of Natural Supports	✓		✓

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

Federal regulations require the PIHP to undergo a CR at least once every three years to determine compliance with federal standards. Table 4-1 delineates the CR standards that were reviewed during the current three-year CR cycle, along with scores for Magellan.

Table 4-1—Summary of CR Scores for the Three-Year Review Period: CY 2021–CY 2023[1,2]

Standard Name	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Enrollment and Disenrollment		**50.0%[2]**	
Member Rights and Confidentiality	97.9%		
Member Information			
Coverage and Authorization of Services	100%		
Emergency and Post-Stabilization Services		**100%[2]**	
Availability of Services	95.1%		
Assurances of Adequate Capacity and Services	97.9%		
Coordination and Continuity of Care	90.0%		
Provider Selection	95.2%		
Subcontractual Relationships and Delegation	100%		
Practice Guidelines	100%		
Health Information Systems	100%		
Quality Assessment and Performance Improvement Program	100%		
Grievance and Appeal Systems	100%		
Program Integrity	100%		

[1] Gray shading indicates the standard was not reviewed in the calendar year.

[2] Bold text indicates scores that were determined by HSAG. All other scores were determined by LDH's former EQRO. HSAG's scoring methodology included three levels: *Met*, *Not Met*, and *Not Applicable*.

Follow-Up on Previous Compliance Review Findings

Following the year two CR, HSAG worked with LDH to issue CAPs for elements in Standard I—Enrollment and Disenrollment and Standard IV—Emergency and Poststabilization Services that were not compliant. The PIHP was required to submit the CAP for approval. Upon approval from LDH and HSAG, the PIHP was required to implement the CAP and submit evidence of implementation. HSAG worked with LDH to review, approve, and monitor CAPs during year three.

Magellan achieved compliance in three out of three elements from the CAP review in year three, demonstrating positive improvements in implementing CAPs.

HSAG will conduct a comprehensive CR during 2025 to determine the extent to which the MCEs are in compliance with federal standards during review period CY 2024.

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- Magellan successfully remediated all three elements, indicating that initiatives were implemented and demonstrated compliance with the requirements under review. **[Quality and Access]**

For Magellan, the following opportunities for improvement were identified:

- HSAG did not identify any opportunities for improvement.

For Magellan, the following recommendations were identified:

- HSAG did not identify any required actions or recommendations.

Methodology

Standards

Table 4-2 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In year three (CY 2023), HSAG conducted a follow-up review of the PIHP's CAPs from the previous CR. HSAG will conduct a comprehensive CR during 2025 to determine the extent to which the PIHP is in compliance with federal standards during the review period CY 2024.

Table 4-2—Summary of CR Standards

Standard	Year One (CY 2021)			Year Two (CY 2022)			Year Three (CY 2023)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment				✓	✓	✓			
Standard II—Member Rights and Confidentiality	✓	✓	✓						
Standard III—Member Information	✓	✓	✓						
Standard IV—Emergency and Poststabilization Services	✓	NA				✓			
Standard V—Adequate Capacity and Availability of Services	✓	✓	✓						
Standard VI—Coordination and Continuity of Care	✓	✓	✓						
Standard VII—Coverage and Authorization of Services	✓	✓	✓						
Standard VIII—Provider Selection	✓	✓	✓						
Standard IX—Subcontractual Relationships and Delegation	✓		✓		✓				
Standard X—Practice Guidelines	✓	✓	✓						
Standard XI—Health Information Systems	✓	✓	✓						
Standard XII—Quality Assessment and Performance Improvement	✓	✓	✓						
Standard XIII—Grievance and Appeal Systems	✓	✓	✓						

Standard	Year One (CY 2021)			Year Two (CY 2022)			Year Three (CY 2023)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard XIV—Program Integrity	✓	✓	✓						
CAP Review							✓	✓	✓

NA=not applicable for the PAHPs

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table 4-3 describes the standards and associated regulations and requirements reviewed for each standard.

Table 4-3—Summary of CR Standards and Associated Regulations

Standard	Federal Requirements Included[1]	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.608

[1] The CR standards comprise a review of all requirements, known as "elements," under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The objective of each virtual review was to provide meaningful information to LDH and the PIHP regarding:

- The PIHP compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the PIHP into compliance with federal managed care regulations and contract requirements with the standard areas reviewed.
- The quality, timeliness, and access to care furnished by the PIHP, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the PIHP's care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess the PIHP's compliance with regulations, HSAG conducted the five activities described in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[4-1] Table 4-4 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 4-4—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and LDH contract requirements: • HSAG and LDH collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted CR tools, report templates, and agendas, and sent review dates to LDH for review and approval. • HSAG forwarded the CR tools and agendas to the PIHP. • HSAG scheduled the virtual reviews to facilitate preparation for the reviews.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 12, 2024.

For this protocol activity,	HSAG completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted a PIHP pre-virtual review preparation session to describe HSAG's processes and allow the PIHP the opportunity to ask questions about the review process and PIHP expectations. • HSAG confirmed a primary PIHP contact person for the review and assigned HSAG reviewers to participate. • During the PIHP pre-virtual review preparation session, HSAG notified the PIHP of the request for desk review documents. HSAG delivered a desk review form, the CR tool, CAP implementation review tool, and a webinar review agenda via HSAG's Secure Access File Exchange (SAFE) site. The desk review request included instructions for organizing and preparing the documents to be submitted. The PIHP provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and CR consisted of the completed desk review form, the CR tool with the PIHP's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct PIHP Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual review activities. • During the review, HSAG met with groups of the PIHP's key staff members to obtain a complete picture of the PIHP's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the PIHP's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the 2023 LDH-approved CR Report Template to compile the findings and incorporate information from the CR activities. • HSAG analyzed the findings and calculated final scores based on LDH-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to LDH**
	• HSAG populated and submitted the draft reports to LDH and the PIHP for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports.

For this protocol activity,	HSAG completed the following activities:
	• HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the PIHP and LDH.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Written policies and procedures
- Management/monitoring reports and audits
- Narrative and/or data reports across a broad range of performance and content areas
- Records for delegation
- Member and provider materials

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual interviews conducted with key PIHP personnel, and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the PIHP's performance in complying with each standard requirement.
- Scores assigned to the PIHP's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to LDH and to the PIHP's staff members for their review and comment prior to issuing final reports.

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and opportunities for improvement in each domain of quality, timeliness, and access to care furnished by the PIHP. HSAG then identified common themes and the salient patterns that emerged across the PIHP related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the PIHP, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the PIHP. Table 4-5 depicts assignment of the standards to the domains of care.

Table 4-5—Assignment of CR Standards to the Quality, Timeliness, and Access Domains

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		
Standard XIII—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Program Integrity	✓	✓	✓

5. Validation of Network Adequacy

Results

NAV Audit

This section presents the results from the CY 2023 (review period) NAV audit.

Based on the NAV audit combined with the virtual review and the detailed validation of each indicator, HSAG determined that Magellan achieved a *High Confidence* validation rating for all indicators, which refers to HSAG's overall confidence that Magellan used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

HSAG determined that Magellan was compliant with network adequacy requirements for all but three provider types. LDH required a 100 percent threshold for Magellan when determining compliance with distance standards. Results that achieved the 100 percent threshold are shaded in green. Table 5-1 contains the percentage of members Magellan reported with access by provider type and by urbanicity.

Table 5-1—Magellan Distance Requirements: Percentage of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity With Indicator	Percentage of Members With Access
Psychiatrists	Urban (15 miles)	99.8%
	Rural (30 miles)	80.9%
Behavioral Health Specialists (psychologists, medical psychologists, APRNs or CNSs, or LCSWs)	Urban (15 miles)	100%
	Rural (30 miles)	94.5%
Specialized Behavioral Health Outpatient Non-MD Services (excluding behavioral health specialists)	Urban (60 miles)	100%
	Rural (90 miles)	100%

HSAG assessed Magellan's results for behavioral health providers and determined that Magellan met all LDH-established performance goals for appointment access standards. Table 5-2 displays the indicator and achieved compliance rate.

Table 5-2—Magellan Appointment Access Standards Compliance Rate for Behavioral Health

Indicator	Reported Compliance Rate
Emergent care 24 hours per day, 7 days per week, within 1 hour of request.	100%

Indicator	Reported Compliance Rate
Urgent care 24 hours per day, 7 days per week, within 48 hours of request.	100%
Routine, non-urgent behavioral healthcare shall be available with an appointment within 14 days of request.	100%

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- Magellan had adequate processes in place to ensure that enrollment and claims data stored in its claims adjudication payment system were accurate and complete. **[Quality, Timeliness, and Access]**

- Magellan had established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and data accuracy review through continuous quality improvement and audit team, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists. **[Quality, Timeliness, and Access]**

For Magellan, the following opportunities for improvement were identified:

- No specific opportunities were identified related to the data collection and management processes Magellan had in place to inform network adequacy standard and indicator calculations.

For Magellan, the following recommendations were identified:

- HSAG did not identify any recommendations for Magellan.

Methodology

Objectives

In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, and PAHPs, collectively referred to as "MCEs," are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the LDH-defined network adequacy indicators reported by the PIHP.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by LDH.

Technical Methods of Data Collection

HSAG collected network adequacy data from the PIHP via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[5-1]

HSAG conducted a virtual review with the PIHP that included team members from the EQRO, PIHP staff, and staff from vendors, if applicable. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for the PIHP included the following:

- Opening meeting
- Review of the ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key PIHP staff members who were involved with the calculation and reporting of network adequacy indicators.

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 12, 2024.

Description of Data Obtained

HSAG prepared a document request packet that was submitted to the PIHP outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the PIHP's IS and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the PIHP to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the PIHP to conduct the NAV audit:

- IS data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Data Were Aggregated and Analyzed

HSAG assessed the PIHP's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the PIHP's and State's network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the PIHP used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

How Conclusions Were Drawn

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 5-3.

Table 5-3—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100
Number of *Not Met* elements determined to have significant bias on the results.

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PIHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 5-4 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-4—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the PIHP provide a root cause analysis of the finding.
- Working with the PIHP to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

By assessing the PIHP's performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG also provided a recommendation to help target improvement.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid PIHP, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-5.

Table 5-5—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Distance	✓	✓	✓
Access and Timeliness Standards	✓	✓	✓

6. PIHP Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2024 to comprehensively assess Magellan's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides Magellan's strengths, opportunities for improvement, and recommendations in Table 6-1 through Table 6-3.

Table 6-1—Strengths Related to Quality, Timeliness, and Access

Overall PIHP Strengths	
Quality, Timeliness, and Access	• Magellan demonstrated strength in its behavioral health provider network by meeting all LDH-established performance goals for appointment access standards for behavioral health providers. • Magellan successfully received *Met* scores for 100 percent of applicable evaluation elements in its PIP.
Quality and Access	• Magellan performed strongly on the performance measure for eligible youth avoiding out-of-home placement and receiving needed services in an HCB setting or a family home.

Table 6-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall PIHP Opportunities for Improvement	
Quality and Access	• Magellan showed opportunity for improvement with performance measures related to eligible youth improving clinical functioning, school functioning, school attendance, and school behavior.

Table 6-3—Recommendations

Overall PIHP Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
HSAG recommends the PIHP review the observed trend of a decline in several quality measures in the third and fourth quarters of CY 2024 and identify the factors that have contributed to the decline in performance.	Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities

7. Follow-Up on Prior Year's Recommendations

Table 7-1 through Table 7-4 contain a summary of the follow-up actions that Magellan completed in response to the EQRO's SFY 2023 recommendations. Furthermore, HSAG assessed Magellan's approach to addressing the recommendations. Please note that the responses in this section were provided by the PIHP and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

HSAG developed a methodology and rating system for the degree to which the PIHP addressed the prior year's EQR recommendations. In accordance with CMS guidance, HSAG used a three-point rating system. The health plan's response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

- The plan implemented new initiatives or revised current initiatives that were applicable to the recommendation.
- Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, the plan identified barriers that were specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

- The plan continued previous initiatives that were applicable to the recommendation.
- Performance improvement was noted that may or may not be directly attributable to the initiative.
- If performance did not improve, the plan identified barriers that may or may not be specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

- The plan did not implement an initiative or the initiative was not applicable to the recommendation.
- No performance improvement was noted *and* the plan did not identify barriers that were specific to the initiative.
- The plan's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic: 

Table 7-1—Follow-Up on Prior Year's Recommendations for PIPs

Recommendations
None identified.

Table 7-2—Follow-Up on Prior Year's Recommendations for Performance Measures

1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
Continue to implement quality interventions that demonstrate measurable gains in improving care coordination, follow-up, and member outcomes.
Response
Describe initiatives implemented based on recommendations: Magellan implemented value-based and performance-based payment initiatives using funding from the American Rescue Plan Act (ARPA) and Magellan Health. These initiatives aimed to improve staff retention, reduce inpatient hospitalizations, increase follow-up appointment attendance, and enhance rates of Licensed Mental Health Professionals (LMHPs) and prescribers.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): 100% of eligible supervisors (31 of 31) and 95.7% of eligible Wraparound Facilitators (WAFs)—157 out of 164—met performance thresholds, earning incentives for reducing hospitalizations and improving follow-up care standards. All nine regions earned staffing incentives, with four achieving 90% of the available incentive and one achieving 70%. Improvements included increased staffing ratios and reduced vacancies.
Identify any barriers to implementing initiatives: Barriers included administrative burdens in monitoring the initiatives and methodology limitations that affected data tracking and incentive calculations.
Identify strategy for continued improvement or overcoming identified barriers: Magellan will implement standardized enhanced Wraparound Agency (WAA) and LMHP rates at 75% above Medicaid rates to streamline processes and sustain improvements. ARPA funding will continue to be administered, with refinements to methodologies to reduce administrative burdens.

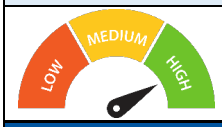
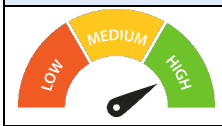
1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
HSAG Assessment

Recommendations
Collaborate with Louisiana Department of Health (LDH) to establish quality metrics (i.e., performance standards) related to the performance measures.
Response
Describe initiatives implemented based on recommendations: Magellan collaborates with the LDH to establish quality metrics for performance measures. Where standards are not yet established, efforts have begun to stratify data by enrollment status, focusing on monitoring indicators such as clinical improvement and natural informal support. Most established indicators, such as provider choice and Plan of Care development, meet 100% compliance goals with a 90% minimum threshold.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2022, Magellan introduced stratification by enrollment period. Natural and informal supports, which are typically low at initial enrollment, had an overall rate of 89.5%. Stratification revealed rates increasing from 79% within the first 180 days of enrollment to 92.4% after 360 days. This trend reflects the effectiveness of the Wraparound model in building community and family support over time.
Identify any barriers to implementing initiatives: Enrollment churn in the Coordinated System of Care (CSoC) program poses challenges, as youth with severe needs transition in and out of the program. This dynamic complicates longitudinal trend analysis and the ability to standardize monitoring for all performance measures.
Identify strategy for continued improvement or overcoming identified barriers: Where standards are not yet established, Magellan will collaborate with the Louisiana Department of Health (LDH) to identify appropriate methodologies, such as applying stratification methods or applying statistical analysis, such as standard deviations and control limits, to identify significant variations. Future considerations include exploring targeted measures, such as specific Child and Adolescent Needs and Strengths assessment items, to support more focused evaluations of clinical and school improvement. These approaches aim to enhance meaningful trend analysis and support sustained quality improvement.
HSAG Assessment


Table 7-3—Follow-Up on Prior Year's Recommendations for Compliance With Medicaid Managed Care Regulations

2. Prior Year Recommendations from the EQR Technical Report for Compliance Review:
Implement additional validation checks to further ensure accurate member-level data prior to submission to Health Services Advisory Group, Inc. (HSAG).

2. Prior Year Recommendations from the EQR Technical Report for Compliance Review:
Response
Describe initiatives implemented based on recommendations: Magellan implemented an internal care management system in July 2023. The focus during 2023 was on staff training and converting reporting processes. The system was configured to collect key member-level data elements, including reason for discharge, goal progress, living setting, and involvement in state agencies, which were previously provided by Wrap Around Agencies (WAA) via the Coordinated System of Care (CSoC) Data Spreadsheet. This shift centralized and standardized data collection, enabling more accurate and reliable reporting.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Key data elements, such as reason for discharge and goal progress, are now collected directly through assessments and notes within the system. Automated data controls have reduced reliance on secondary sources, increasing the accuracy and integrity of member-level data. Initial validation checks indicate improved alignment with state reporting requirements.
Identify any barriers to implementing initiatives: Initial implementation of the system encountered glitches that impacted data capture and report generation. Additionally, the focus on converting reporting processes delayed the production of timely and accurate required reports. Staff also required additional support and training to utilize the system's capabilities fully.
Identify strategy for continued improvement or overcoming identified barriers: Magellan initiated comprehensive data validation checks by comparing historical spreadsheet data with the new system's records. Errors are investigated, corrected, and incorporated into routine validation processes. In August 2024, Magellan began implementing an external electronic health record (EHR) platform with specially configured assessment and care planning tools to enhance automated data controls and reduce reliance on secondary sources. Transition plans include staff training, regular audits, and contingency workflows to mitigate potential risks during implementation. These efforts aim to improve data accuracy and streamline care planning processes.
HSAG Assessment


Table 7-4—Follow-Up on Prior Year's Recommendations for Network Adequacy

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
To improve access to care, Magellan should: • Focus contracting efforts on rural areas for the three provider types that did not meet GeoAccess standards. • Conduct an in-depth review of rural access to behavioral health providers. • Offer additional telehealth services as appropriate.
Response
Describe initiatives implemented based on recommendations: 1. An evaluation of provider records was conducted to validate elements were in place needed for inclusion in GeoAccess reports. As a result, 22% of provider records failed to have the necessary data. Once updated and reports were reproduced, the average increase was 4% in rural areas. There was no negative impact on access due to the discrepancy as all providers were available to members via the provider directory.

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
2. Conducting a disruption of Coordinated System of Care (CSoC) contracted providers and providers contracted for other lines of business with Magellan. Providers not contracted for Coordinated System of Care (CSoC) will be contacted to seek interest in joining the network. Identification of providers expected to be completed by year end 2024 and outreach to begin Q1 2025. 3. Include provisionally licensed staff for GeoAccess. 4. Add roster staff for GeoAccess. Telehealth continues to fill gaps and remains a widely used method for delivering services in both rural and urban settings. It has become a desirable method for members and families and is availability at their choice.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): While the evaluation of provider data accuracy resulted in a slight increase in rural areas, a continuous evaluation of provider data will continue to maintain provider record and reporting accuracy.
Identify any barriers to implementing initiatives: No barriers identified for initiatives 1 and 2. Will require guidance from Louisiana Department of Health (LDH) to include provisionally licensed. Roster staff inclusion will require additional evaluation for level of effort on reporting logic changes.
Identify strategy for continued improvement or overcoming identified barriers: Collaborate with Louisiana Department of Health (LDH) on requirements for including provisionally licensed staff in reporting. Continue collaboration with Louisiana Department of Health (LDH) regarding percentage of compliance (100%) due the uniqueness of the program and small member population.
HSAG Assessment


Appendix A. PIHP Response to the Health Disparities Focus Study

PIHP Verbatim Response to HSAG's Health Disparities Questionnaire[A-1]

For the annual EQR technical report, HSAG requested information from Magellan regarding its activities related to identifying and/or addressing gaps in health outcomes and/or healthcare among its Medicaid population according to at-risk characteristics such as race, ethnicity, gender, and geography. Magellan was asked to respond to the following questions for the period of July 1, 2023, through June 30, 2024:

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

[A-1] Please note that the narrative within the MCE Response section was provided by the MCE and has not been altered by HSAG except for formatting.

Addressing Behavioral Health Disparities: Magellan's Initiatives and Achievements in the CSoC Program (FY 2024)

Numerous studies have highlighted disparities in access to, utilization, and the quality of behavioral health services, particularly among minority populations, individuals of low socioeconomic status, and those residing in rural areas. These disparities significantly impact both short- and long-term health outcomes. The Coordinated System of Care (CSoC) program is uniquely positioned to directly address many of these known disparities in Louisiana. Through partnerships with nine regional Wraparound Agencies, CSoC collaborates with youth and their families to develop and implement care plans rooted in the principles of the Wraparound model.

This document outlines the initiatives undertaken by Magellan during fiscal year 2024 (July 1, 2023 – June 30, 2024) to reduce disparities in access to and quality of care.

Addressing Disparities in Behavioral Health through CSoC

Behavioral health disparities—particularly among minority populations, low-income individuals, and rural communities—are often driven by barriers such as high costs, limited services, and transportation challenges. The CSoC program addresses these barriers through its Wraparound model, which focuses on individualized, culturally competent care. Key interventions include:

- **Culturally Competent Assessments**: Certified providers conduct assessments at enrollment and every 180 days to identify behavioral health needs, including Social Determinants of Health (SDoH), trauma, and co-occurring conditions. Tools such as the CANS and ACEs questionnaires ensure holistic care that addresses cultural and linguistic needs.
- **Wraparound Facilitator (WAF) Training**: Each youth is paired with a WAF who receives specialized training to work with diverse populations, helping families navigate barriers and ensuring access to culturally appropriate services.
- **Individualized Plans of Care (POCs)**: Each POC is customized to address the youth's behavioral, physical, and social needs. Magellan's Care Managers regularly review the POCs to ensure alignment with family goals and changing needs.
- **Monthly Feedback and Monitoring**: WAAs survey youth and families monthly to monitor POC implementation. Identified barriers, such as service access or transportation issues, are promptly addressed.
- **Care Coordination for Physical and Behavioral Health**: A Managed Care Organization Liaison bridges gaps between behavioral and physical health services, ensuring access to medications and specialists.

Demographic Analysis

Magellan's Coordinated System of Care (CSoC) continues to address disparities in accessing behavioral health services among subpopulations that historically face barriers to care, such as those in rural areas and from diverse racial and ethnic backgrounds. Data from 2023 highlights CSoC's ongoing efforts to penetrate these subpopulations, ensuring that underserved youth receive appropriate services.

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- **Geographic Classification and Access to Care**: In 2023, **74.9%** of CSoC members resided in rural areas, reflecting the program's focus on reaching rural youth, who often face significant barriers to behavioral health services due to fewer providers, limited transportation, and lack of resources. By enrolling a large portion of rural youth, Magellan actively mitigates geographic disparities through Wraparound Facilitators (WAFs) who help families develop individualized Plans of Care (POCs). Additionally, specialized waiver services like peer support and respite care are provided in the home and community, ensuring accessibility regardless of location or financial constraints. Refer to **Figure 1** in the Appendix.
- **Socioeconomic Context**: Louisiana has one of the highest poverty rates in the nation, with **24.6%** of children living in poverty in 2022. These socioeconomic challenges further limit access to behavioral health services. CSoC's focus on delivering home-based services and addressing Social Determinants of Health (SDoH), such as transportation and resource availability, plays a critical role in reducing these disparities and ensuring that families can fully engage in care.
- **Gender and Access Trends**: In 2023, the gender distribution of CSoC members remained **44.1% female** and **55.9% male**, with a gradual increase in female enrollment since 2020. Magellan continues to monitor gender trends to ensure equitable access to services for all youth. Refer to **Figure 2** in the Appendix.
- **Racial and Ethnic Representation**: CSoC continues to reach minority groups that are often underserved in behavioral health services. In 2023, **51.7%** of CSoC members identified as Black/African American, compared to **50.2%** in 2022, while **44.2%** identified as White. Magellan's focus on increasing enrollment among racial and ethnic minorities aligns with broader efforts to reduce disparities in behavioral health outcomes for these groups. Refer to **Figure 3** in the Appendix.

Magellan's targeted initiatives within CSoC have been effective in reducing access disparities, particularly for rural, low-income, and minority populations. By offering home-based services and individualized care planning, CSoC ensures that underserved youth receive the support they need. Ongoing demographic monitoring and strategic interventions will continue to address gaps in care and improve outcomes for all CSoC members.

Reducing Health Disparities through Targeted Interventions

Disparities in behavioral health services disproportionately affect minority populations, low-income individuals, and those in rural areas, creating significant gaps in both mental and physical health outcomes. The Coordinated System of Care (CSoC) program addresses these disparities by embedding Social Determinants of Health (SDoH) into its core model, ensuring equitable access to care. Key initiatives are discussed below.

- **Culturally Competent Assessments:** Every CSoC youth undergoes a comprehensive assessment by a certified provider at enrollment and every 180 days. Tools like the CANS assessment and the ACEs questionnaire ensure that behavioral health, trauma, and co-occurring needs are evaluated with attention to cultural and linguistic factors. This approach ensures that care plans are reflective of the youth's specific cultural background.
- **Tailored Wraparound Support:** Each youth is paired with a Wraparound Facilitator (WAF) who receives specialized training to address cultural nuances and reduce access barriers for diverse populations. Facilitators help families access necessary services, such as transportation or community-based supports, ensuring that barriers tied to SDoH are addressed.
- **Customized Plans of Care (POCs):** Each POC is personalized to meet the unique behavioral and social needs of the youth, including risk factors and SDoH. These plans are regularly reviewed and adjusted by Care Managers to ensure that services remain aligned with the youth's evolving needs.
- **Collaborative Health Coordination:** The Managed Care Organization Liaison works to resolve challenges related to accessing physical health services and medications. This role ensures that youth can access both

behavioral health and physical health services seamlessly, addressing gaps in care coordination between the two.

Through these initiatives, CSoC actively reduces disparities by incorporating SDoH and cultural factors into every stage of care, enhancing health outcomes for vulnerable youth populations. These efforts are specifically designed to reduce differences in health outcomes, status, and care quality among CSoC members across Medicaid subgroups, such as race, ethnicity, gender, age, socioeconomic status, and geography.

Impact on Social Determinants of Health (SDoH)

Magellan utilizes the Child and Adolescent Needs and Strengths (CANS) assessment to evaluate the impact of Social Determinants of Health (SDoH) on youth and families within the Coordinated System of Care (CSoC) program. CANS assessments, conducted at enrollment and every 180 days, identify both risk factors and protective strengths. This helps inform targeted interventions designed to address needs related to relationship stability, school attendance, family stress, trauma exposure, caregiver knowledge, and resilience—all crucial factors linked to youth's physical, mental, and social well-being.

Key Findings

Data is collected at two key points—enrollment and discharge—enabling a comparison of the prevalence of actionable needs (CANS items rated 2 or 3) and protective strengths. Reductions in actionable needs, alongside increases in strengths, reflect the effectiveness of CSoC interventions in addressing critical SDoH factors.

An analysis of 2023 CANS data (N = 1,156) revealed significant reductions in actionable needs across all SDoH-related categories, demonstrating that CSoC's interventions have effectively mitigated social and environmental barriers impacting youth and families. Refer to Figures 4 and 5 in the Appendix for detailed data.

- **Family Stress**: At enrollment, 90.4% of families had actionable needs related to managing youth emotional and behavioral challenges. Actionable needs decreased by 39.1 percentage points, reflecting reduced family stress.
- **School Functioning**: Initial data showed that 76.6% of youth faced challenges related to school attendance, behavior, or achievement. Challenges in school attendance and behavior dropped from 76.6% at enrollment to 42.0% at discharge.
- **Trauma**: Youth with actionable trauma-related needs dropped from 46.8% at enrollment to 27.0% at discharge, showcasing CSoC's capacity to address trauma effectively.
- **Social Supports**: Caregivers with actionable needs related to accessing social resources fell from 37.4% to 23.4%, illustrating the program's efforts to build strong social networks and supports for long-term care.

In addition to reductions in actionable needs, CSoC interventions have successfully enhanced youth and caregiver strengths:

- **Resiliency**: A 35.0 percentage point reduction in actionable needs related to youth resilience. (from 95.2% at enrollment to 60.2% at discharge).
- **Optimism**: Optimism, a key protective factor, improved by 31.1 percentage points, underscoring the program's positive impact on youth aspirations and outlook.
- **Educational and Talents/Interests**: Both areas improved by 25.4 percentage points, indicating the program's success in advocating for educational support and fostering youth talents.
- **Caregiver Knowledge**: Caregiver understanding of their child's needs increased by 20.7 percentage points, with over 80% of caregivers rated as knowledgeable at discharge.

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Magellan HEALTHCARE

In 2024, Magellan will further enhance its ability to track and analyze SDoH with the implementation of Opeeka's Person-Centered Intelligence Solution (P-CIS) platform. This new technology will streamline the connection between CANS assessments and Plans of Care, ensuring that identified needs and strengths are systematically addressed. This development will facilitate even greater collaboration between caregivers, facilitators, and assessors, ultimately reducing disparities in access and care quality.

Member Experience of Care: Analysis of Satisfaction by Subpopulations

Magellan utilizes the Member Experience of Care survey to assess disparities in health outcomes, access, and satisfaction among subpopulations within the CSoC program. The 2023 survey, completed by 290 participants, focused on service aspects such as accessibility, cultural competence, provider interactions, and overall satisfaction with service availability and effectiveness. These insights guide ongoing efforts to monitor and address disparities in care across different demographic groups.

- **Overall Satisfaction**: In 2023, **91.0%** of respondents reported positive satisfaction with CSoC services, while **5.2%** were neutral, and **3.8%** expressed dissatisfaction. Satisfaction was measured on a 5-point scale, assessing aspects such as service effectiveness, availability, and provider involvement.
- **Satisfaction by Racial Group**: Satisfaction levels across racial groups were consistently high. Black/African American respondents (n=130) reported the highest mean satisfaction score (**M=4.57, SD=0.77**), followed by White respondents (n=117) with a mean of **4.39** (**SD=0.79**), and the Other/Multi-racial group (n=37) with a mean of **4.27** (**SD=1.04**). An ANOVA test yielded a **p-value of 0.079**, indicating no statistically significant differences in satisfaction across racial groups. This suggests equitable access and satisfaction across racial demographics.
- **Satisfaction by Gender**: Male respondents (n=167) reported slightly higher satisfaction (**M=4.54, SD=0.68**) compared to female respondents (n=117), who had a mean score of **4.31** (**SD=0.97**). A Mann-Whitney U test produced a **p-value of 0.069**, showing no significant gender-based disparities in satisfaction levels. This confirms that CSoC services are delivered equitably across genders.

The 2023 survey results demonstrate consistently high satisfaction across all demographic subgroups, with no significant disparities identified based on race or gender. These findings reinforce CSoC's commitment to providing accessible, culturally competent care. Magellan's continuous monitoring through surveys allows for the prompt identification and resolution of any emerging disparities in service delivery, provider involvement, , or overall effectiveness.

Intellectual/Developmental Disabilities (I/DD)

CSoC youth with co-occurring behavioral health and intellectual/developmental disabilities (I/DD) require coordinated support from the Office of Citizens with Developmental Disabilities (OCDD). As the Single Point of Entry (SPOE) into Louisiana's developmental disabilities services, OCDD oversees services such as home- and community-based supports and residential care. Magellan ensures that youth are screened for potential I/DD during clinical eligibility assessments and care management reviews, allowing timely referrals to OCDD services and linking them to long-term supports.

In 2022, **75** CSoC youth (1.9%) were eligible for OCDD waivers, and this number rose to **105** (2.8%) in 2023, reflecting a growing recognition of the need for integrated services. Refer to **Figure 6** in the Appendix. Magellan has implemented several key initiatives to reduce disparities in access to I/DD services for these youth, including:

- **Screening and Referral Processes**: Magellan prioritizes early identification and referral to OCDD services. This proactive approach helps link youth to vital long-term supports through the OCDD waiver system.

- **Development of Clinical Tools and Training**: Magellan's Medical Director, Dr. Jamie Hanna, participated in the Louisiana Dual Diagnosis Workgroup, which developed guides to help providers and families navigate I/DD and mental health systems. These tools support informed decision-making and access to appropriate services.
- **Expansion of Developmental and Educational Procedures**: Magellan's "Developmental and Educational Procedures" ensure that youth with developmental challenges receive appropriate support. The framework helps integrate I/DD services into Plans of Care (POCs), while educating families about school-based services (e.g., IEPs, 504 Plans) and the OCDD waiver process.
- **Enhanced Training for Wraparound Facilitators and Assessors**: In 2023, Magellan provided specialized training on identifying I/DD and connecting families to OCDD services. Training sessions focused on navigating IEPs, 504 Plans, and the OCDD waiver process, ensuring staff were equipped to support families effectively.
- **Care Management Oversight**: Magellan's Care Management team uses the POC Review Tool to monitor compliance in integrating I/DD services into care plans. Compliance rates for addressing developmental needs in POCs were consistently high in 2022 and 2023, demonstrating a strong commitment to reducing disparities for youth with I/DD.
- **Remediation Processes**: When developmental needs are not adequately addressed in POCs, Magellan's remediation process ensures that Wraparound Agencies quickly update plans. This swift response improves outcomes by ensuring that strategies for addressing I/DD needs are in place.
- **Discharge Outcomes**: Improvements in educational strengths and school functioning among discharged youth underscore the effectiveness of Magellan's approach. In 2023, CANS data showed reductions in actionable needs related to educational strengths (from **60.3%** to **34.9%**) and school functioning (from **76.6%** to **41.9%**).
- **Provider Training for I/DD and Mental Health Comorbidities**: In 2024, Magellan expanded training for clinicians, focusing on managing dual diagnoses of I/DD and mental health. Continuing education sessions led by experts such as Dr. Dan Baker emphasized clinical competencies and evidence-based interventions for this population, helping reduce disparities in care access and improving provider competency.

Magellan remains committed to closing gaps in care for CSoC youth with I/DD. Through enhanced screening, coordinated care, training, and remediation processes, the organization continues to provide comprehensive and continuous support, reducing disparities and improving outcomes for youth with developmental disabilities across Louisiana.

Youth Involved with Child-Serving State Agencies

CSoC members frequently engage with multiple child-serving state agencies, including the Department of Education (DOE), the Department of Children and Family Services (DCFS), and the Office of Juvenile Justice (OJJ). CSoC's coordinated network integrates these agencies to provide comprehensive support for youth and families, under the oversight of the CSoC Governance Board. Many youth living in out-of-home settings, such as group homes or detention centers, experience a higher incidence of mental health disorders, often stemming from trauma, abuse, or neglect.

Between 2021 and 2023, data showed a rise in CSoC youth involved with DCFS, OJJ, or both agencies. The average percentage of youth with any involvement in DCFS or OJJ increased from **22.3% in 2021** to **24.3% in 2023**. Notably, DCFS involvement rose steadily from **11.2% in 2021** to **13.0% in 2023**, while OJJ involvement remained relatively stable between **9% and 10%**. Youth with dual involvement in both agencies represented a smaller percentage, at **1.8% in 2023**.

To address the complex needs of CSoC youth involved with state agencies, Magellan implemented several high-impact initiatives aimed at reducing disparities in access to care and improving collaboration between agencies:

- **Direct Referral Process**: Launched in 2021 and continuing through 2023, the direct referral process was designed to simplify access to CSoC services for youth involved with DCFS and OJJ. By streamlining the referral system for state agency employees—who often manage large caseloads—this intervention facilitated quicker access to CSoC services. The increasing rates of youth involvement suggest the success of this process in ensuring timely service access.
- **State Agency Liaison Role**: Magellan employs a dedicated State Agency Liaison to coordinate care between CSoC providers and child-serving agencies. In 2023, this role expanded to enhance collaboration through presentations to key stakeholders, such as judges, Families in Need of Services (FINS) employees, and DCFS staff in Regions 3 and 6. These presentations covered:
  - Enhancing communication between state agencies and court representatives.
  - Educating stakeholders on CSoC's mission and referral processes.
  - Identifying youth who could benefit from CSoC enrollment and describing available waiver services. Additionally, the liaison conducted training for newly hired OJJ and OCDD staff, focusing on effective collaboration strategies and understanding youth needs within the wraparound framework.
- **Agency and Provider Collaboration**: Throughout 2023, Magellan prioritized stronger partnerships with state agencies and community providers. The State Agency Liaison represented Magellan at key events such as the Governor's Conference on Juvenile Justice and the Louisiana Judicial Conference. These efforts helped foster connections to better serve youth with complex needs. In collaboration with the Family Support Organization and Intensive Legal Services Branch (ILSB) providers, the liaison worked to address specific member challenges and refine service delivery to improve care coordination.

Conclusion

In conclusion, Magellan's Coordinated System of Care (CSoC) program has made significant strides in reducing behavioral health disparities through targeted interventions, enhanced care coordination, and ongoing collaboration with state agencies. By addressing Social Determinants of Health (SDoH), expanding access to care for rural and minority populations, and supporting youth with intellectual and developmental disabilities (I/DD), Magellan ensures that underserved youth receive comprehensive, culturally competent care. Through continuous monitoring, tailored training, and strategic partnerships, CSoC is positioned to close gaps in access and improve behavioral health outcomes for vulnerable youth across Louisiana. These efforts reflect Magellan's commitment to fostering equity, ensuring that all youth have the opportunity to thrive in their communities.

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Appendix

Figure 1. Geographic Classification on the Last Day of the Year, 2020 – 2023

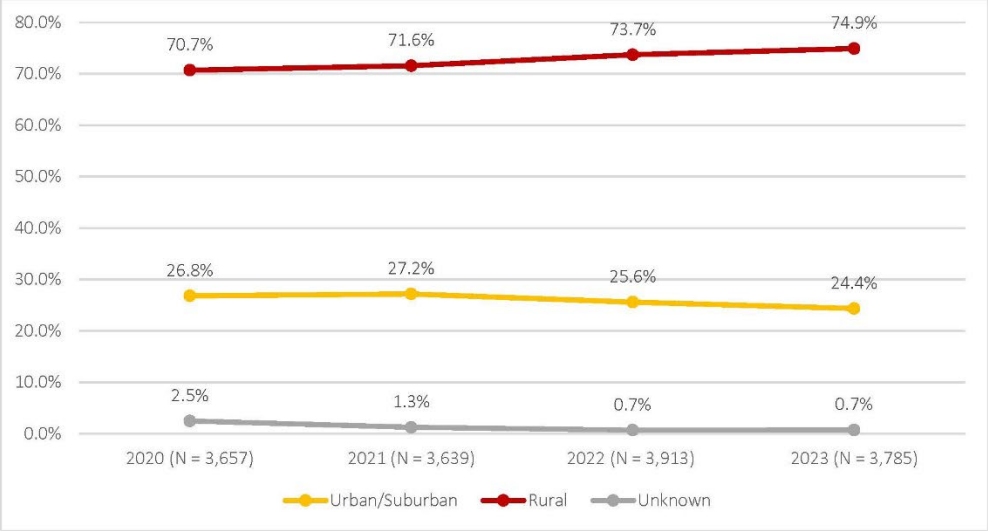

Figure 2. Gender of CSoC Members

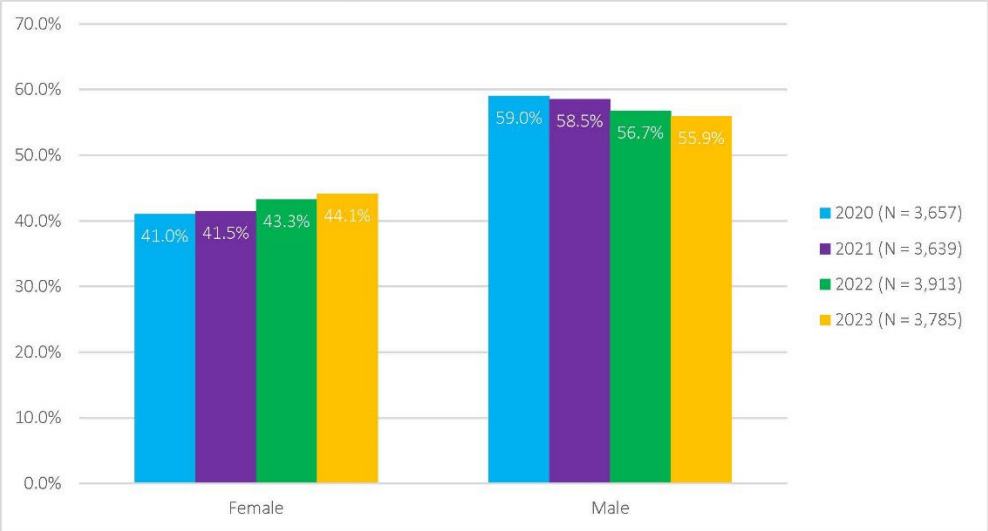

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Figure 3. Race of CSoC Members, 2020 - 2023

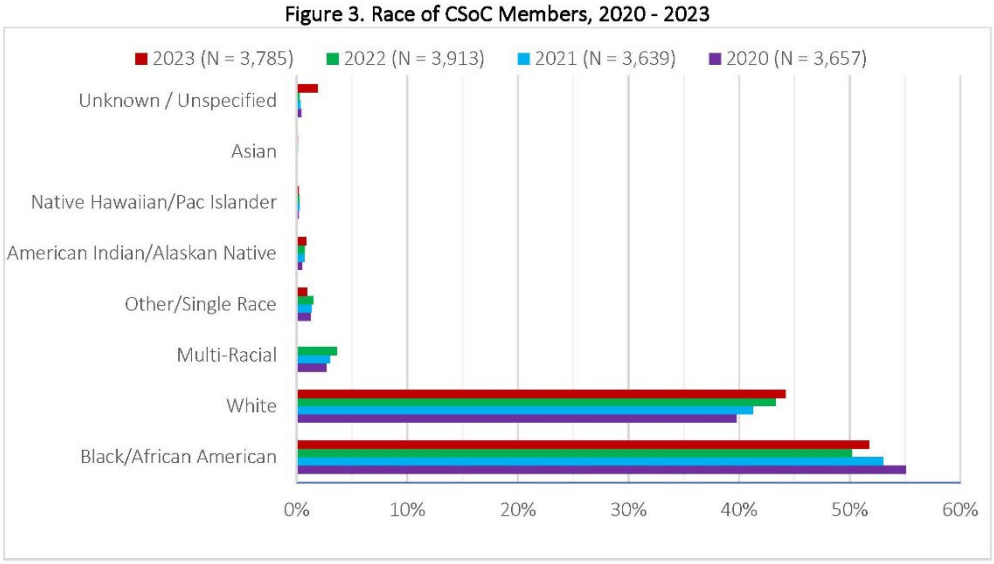
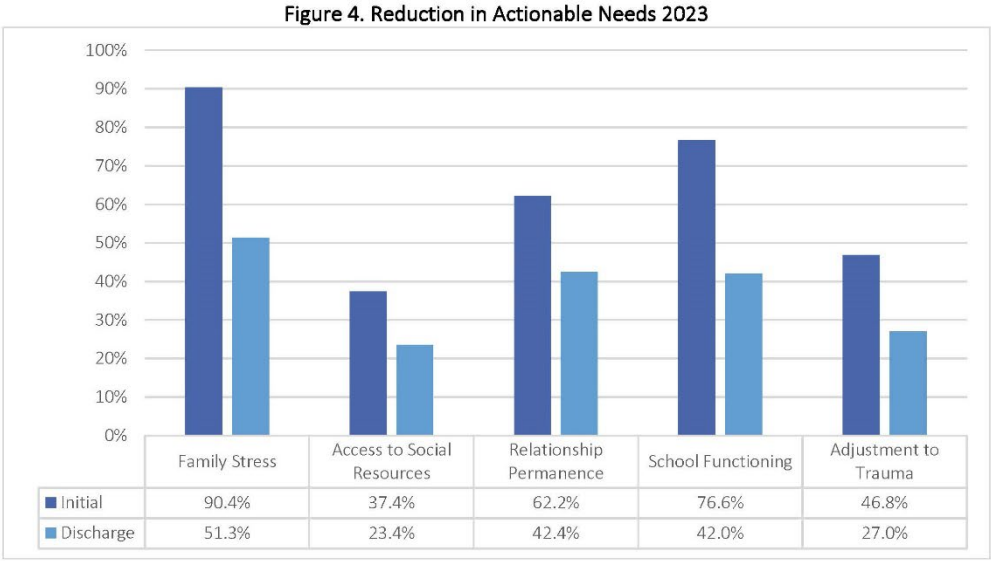
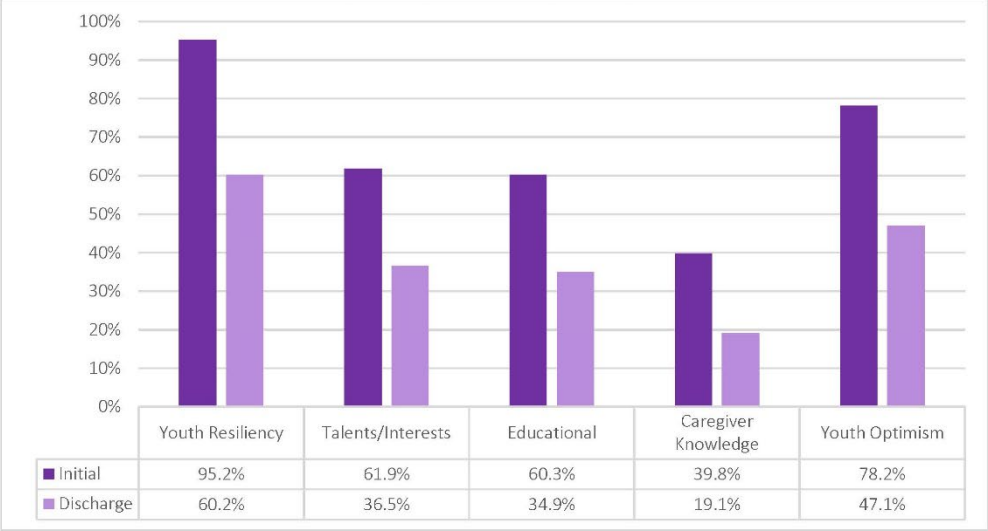


Figure 4. Reduction in Actionable Needs 2023



	Family Stress	Access to Social Resources	Relationship Permanence	School Functioning	Adjustment to Trauma
Initial	90.4%	37.4%	62.2%	76.6%	46.8%
Discharge	51.3%	23.4%	42.4%	42.0%	27.0%

Figure 5. Improvements in Strength Items 2023



	Youth Resiliency	Talents/Interests	Educational	Caregiver Knowledge	Youth Optimism
Initial	95.2%	61.9%	60.3%	39.8%	78.2%
Discharge	60.2%	36.5%	34.9%	19.1%	47.1%

Figure 6. CSoC and OCDD Dual Waiver Eligibility by Year