LOUISIANA DEPARTMENT OF HEALTH

State Fiscal Year July 1, 2024–June 30, 2025

External Quality Review Technical Report

for

Magellan of Louisiana

March 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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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] with further revisions released in November 2020.[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 (CSoC) 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 health care 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] 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 31, 2025.

[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 31, 2025.

health PIHP, CSoC contractor, to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2025 (July 1, 2024–June 30, 2025) 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.[3] For the SFY 2025 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	CMS EQR 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	✓	✓	✓

[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 31, 2025.

EQR Activities	Description	CMS EQR 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.				
Encounter Data Validation (EDV)	This activity validates the accuracy and completeness of encounter data submitted by an MCO.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan	✓	✓	✓
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	✓		
CAHPS Dental Survey	This activity reports the results of each PAHP's CAHPS Dental Survey 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	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management (CM) services to determine the number of individuals, the types of conditions, and the impact that CM 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 2025. 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 2025 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 accessibility of 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[4]

Strengths

Overall, the quality strategy serves to effectively measure and improve the quality of Louisiana's Medicaid managed care services. LDH's initiatives are tied 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

[4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2024–March 19, 2025, November 2025. Available at: https://ldh.la.gov/assets/docs/MQI/LA_2025_QSE-Report_F1.pdf. Accessed on: Dec 31, 2025.

quality strategy in 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 still plans to include the requirement for a commitment to QI in the PAHP contract.

The EQRO has identified the following strengths:

- In support of Goal 3, "Facilitate patient-centered, whole-person care," the MCEs demonstrated strong adherence to PIP methodology, with most projects scoring 100 percent on critical validation elements and achieving *High Confidence* ratings related to proper study design, data collection, and intervention planning.
- In support of Goal 1, "Ensure access to care to meet enrollee needs," LDH has established comprehensive network adequacy standards and monitoring processes that support access to care, as demonstrated by strong performance across multiple plan types. All MCEs met or exceeded provider-to-member ratio requirements and key behavioral health timeliness standards, and the PIHP achieved *High Confidence* ratings across all validated indicators with full compliance on appointment access standards. These results reflect a solid oversight structure and a generally adequate provider network to support timely access to behavioral and medical services for most members statewide.

Recommendations

The EQRO has identified the following recommendations for the quality strategy:

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH:
  - Establish clear, system-level performance goals within the quality strategy to define the intended direction and outcomes of improvement efforts.
  - Select a streamlined, high-impact set of priority measures that will serve as key indicators of progress toward these goals, reducing the overall number of measures and focusing improvement on LDH's highest priorities.
  - Ensure all goals and objectives—including those related to PAHPs and PIHPs—are supported by corresponding performance measures within the quality strategy.
  - Define baselines for the selected priority measures to support ongoing measurement, monitoring, and evaluation of performance over time.
  - Refine the measure set by eliminating retired, not reportable, and not applicable measures.
  - Align the quality withhold incentive program with the streamlined priority measure set to ensure that financial incentives are focused on the measures most critical to advancing LDH's system-level performance goals.
  - Strengthen the quality withhold incentive program to be outcome focused, ensuring that withhold payments are earned for demonstrated improvement or sustained high performance on priority measures.

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH increase its quality strategy evaluation to a three-year period. The evaluation of the effectiveness of the quality strategy should be conducted within the previous three years.
- To target improvement in Goal 2, "Improve coordination and transitions of care," HSAG recommends that LDH work with the MCOs to improve follow-up after emergency department (ED) and hospital visits for mental health and substance abuse.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH work with the PAHPs to increase the percentage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) enrollees receiving preventative dental services.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH use Medicaid data and performance measure results to identify populations with low rates of preventive and screening services, and require targeted outreach and interventions from the MCEs to increase completion of recommended services.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends that LDH strengthen oversight of member-experience performance by aligning CAHPS priorities with the quality strategy's goals and requiring the MCEs to determine factors contributing to persistently low or stagnant CAHPS scores, and implement focused improvement strategies while promoting interventions shown to improve access, communication, and member engagement.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH require the MCEs to achieve and maintain accurate, complete, and up-to-date provider directories by establishing clear data quality standards, enforcing routine audits, and imposing corrective actions when minimum accuracy thresholds are not met.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH strengthen oversight and collaboration with the dental PAHPs to improve network adequacy in parishes that did not meet distance standards by developing targeted remediation plans, prioritizing recruitment in high-need areas, and implementing ongoing monitoring to ensure members can obtain timely dental care across urban and rural regions.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH strengthen monitoring and follow-through on corrective actions for recurring operational deficiencies related to non-emergency medical transportation (NEMT) timeliness and provider payment to ensure compliance with contract requirements and prevent member access barriers.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH collaborate with the MCEs and providers to improve timely access to prenatal and postpartum care and reduce preventable adverse birth outcomes. Efforts should focus on identifying and addressing barriers to early and continuous prenatal care, implementing provider-level interventions to promote appropriate delivery practices and reduce low-risk cesarean rates, and enhancing outreach and care coordination to support postpartum follow-up and healthy birth outcomes.

Actions on External Quality Review Recommendations

The EQRO identified the following recommendations for the quality strategy during the last review period, March 20, 2023–March 19, 2024. 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—EQRO Recommendations and LDH Actions

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that 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 (SDOH). • Advance value-based payment arrangements and innovation. • Ensure members who are improving or stabilized in hospice are considered for discharge.	LDH has alternative mechanisms to monitor and track these objectives and declines to add new performance measures at this time.
To target improvement in Goal 3, "Facilitate patient-centered, whole person care," HSAG recommended that LDH include performance measures for the PAHPs and PIHP in the quality strategy.	LDH agrees with this recommendation and has made this change in the upcoming Quality Strategy revisions.
To target improvement in Goal 3, "Facilitate patient-centered, whole person care," HSAG recommended that LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.	LDH agrees and will incorporate the PAHPs into the MCO PIP process beginning in calendar year (CY) 2026. The PAHPs will use the same submission guidelines and timeline and will also attend quarterly PIP meetings.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended 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	LDH currently works with the MCOs collaboratively during quarterly PIP meetings. LDH works with all MCEs at quarterly MAC meetings. The MAC consists of

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
measures in the quality strategy that have not met improvement objectives and target objectives.	MCE chief medical officers. Best practices are discussed frequently. In addition, LDH meets with the MCO CEOs and other support staff during quarterly business reviews to discuss recommendations and best practices.
To improve MCO performance in Goal 6, "Partner with communities to improve population health and address health disparities," HSAG recommended that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans (HEPs) and the progress being made through quality interventions to reduce health disparities.	LDH attends MCO quarterly QAPI Committee meetings, where its HEP components and progress being made toward HEP goals are discussed. LDH also reviews and approves the MCOs' QAPI Plan and related progress reports annually and provides feedback to the MCOs as needed. LDH also provides feedback to the MCOs on their twice-yearly HEP submissions.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.	LDH agrees. These updates were made in the pending revised Quality Strategy.
To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommended that LDH assess MCO failure to provide NEMT and have the MCOs implement interventions to improve provision of NEMT and ensure it is timely and accessible.	LDH agrees and also assesses MCO failure to provide NEMT and requires the MCOs to 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 recommended that 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.	LDH agrees and already assesses areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty, including identifying root causes and planned interventions through a corrective action plan (CAP).
HSAG recommended that LDH report rates for the following measures included in Appendix B of the quality strategy: • *Enrollment by Product Line* • *Language Diversity of Membership* • *Race/Ethnicity Diversity of Membership*	MCOs are already required to report these measures. They are not included on the Medicaid Quality Dashboard because they are statistical in nature and not performance based.

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 2025.

Validation of Performance Improvement Projects

For the SFY 2025 PIP validation, the PIHP submitted for validation the design, implementation, and Remeasurement 1 outcomes of a PIP focused on the quality of wraparound care plans and use of evidence-based practices (EBPs) in wraparound care plans for youth in the eligible population. Magellan progressed to reporting Remeasurement 1 performance indicator results and interventions for the PIP during the third validation cycle in SFY 2025. HSAG assigned the PIHP's PIP submission *High Confidence* for Validation Rating 1, Overall Confidence of Adherence to 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]),[5] and *Moderate Confidence* for Validation Rating 2, Overall Confidence that the PIP Achieved Significant Improvement (Step 9 of the CMS EQR Protocol 1).

Validation of Performance Measures

HSAG's validation of the PIHP's performance measures confirmed compliance with the standards of 42 CFR §438.330(a)(1). The results of the validation activity determined that the PIHP was compliant with the standards of 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 all measures. For the *Follow-Up After*

[5] 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 31, 2025.

Hospitalization for Mental Illness measure, the PIHP used modified HEDIS specifications in measurement year (MY) 2022 but followed HEDIS specifications to calculate rates in MY 2023 and MY 2024. As a result, HSAG cannot compare MY 2023 and MY 2024 rates on the *Follow-Up After Hospitalization for Mental Illness* measure to rates reported by the PIHP in MY 2022.

Assessment of Compliance With Medicaid Managed Care Regulations

During 2025, HSAG reviewed 14 standards which represented all federal standards pursuant to 42 CFR Part 438. HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions. For any standard demonstrating less than 100 percent compliance, Magellan must develop a CAP to address each requirement found to not exhibit full compliance.

Table 1-4—Summary of CR Scores for the Review Period: CY 2024

Standard #	Standard Name	CY 2024
I	Enrollment and Disenrollment Requirements and Limitations	100%
II	Member Rights and Confidentiality	100%
III	Member Information	88%
IV	Emergency and Poststabilization Services	100%
V	Adequate Capacity and Availability of Services	82%
VI	Coordination and Continuity of Care	100%
VII	Coverage and Authorization of Services	90%
VIII	Provider Selection	58%
IX	Subcontractual Relationships and Delegation	NA
X	Practice Guidelines	83%
XI	Health Information Systems	100%
XII	Quality Assessment and Performance Improvement	100%
XIII	Grievance and Appeal Systems	84%
XIV	Program Integrity	89%
Total Compliance Score		**89%**

Validation of Network Adequacy

Table 1-5 contains the percentage of members Magellan reported with access at the statewide level, by provider type and by urbanicity. LDH established a 100 percent threshold for Magellan when determining requirements met with distance standards. Results that achieved the 100 percent threshold are shaded in green and marked with an up arrow.

Table 1-5—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)	100%↑
	Rural (30 miles)	87.8%
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)	92.8%
Specialized Behavioral Health Outpatient Non-Doctor of Medicine (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 1-6 displays the indicators and achieved compliance rates for behavioral health.

Table 1-6—Magellan Appointment Access Standard Compliance Rates for Behavioral Health

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

Encounter Data Validation

Information Systems Review

The information systems (IS) review provides self-reported qualitative information from the PIHP about its encounter data processes. Table 1-7 summarizes the strengths and weaknesses from the IS review. Cells with a "✓" indicate a strength, cells with an "X" indicate a weakness, and cells with an "—" indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

Table 1-7—Summary of Strengths and Weaknesses From IS Review

IS Review	PIHP		Note
Encounter Data Sources and Systems	—		None.
Payment Structures	—		None.
Encounter Data Quality Monitoring			
Quality Monitoring on Encounters Collected by Magellan	X		Weakness was for all encounters collected by Magellan.
% of Encounters Initially Rejected and Not Yet Accepted by LDH	✓	X	Strength was for institutional encounters. Weakness was for professional encounters.

Administrative Profile

The administrative profile analyzes LDH's encounter data, for the PIHP, for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Table 1-8 summarizes the strengths and weaknesses stratified by encounter type. Cells with a "✓" indicate a strength, cells with an "X" indicate a weakness, and cells with an "—" indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

Table 1-8—Summary of Strengths and Weaknesses From Administrative Profile

Administrative Profile	Professional	Institutional
Encounter Data Completeness		
Monthly Encounter Volume per 1,000 MM	—	—
Monthly Payment Amount PMPM	—	—
TPL Payment Amount PMPM	—	—
% of Duplicate Encounters	✓	✓
Encounter Data Timeliness		
Lag Between PIHP Payment Date and Received Date by LDH	X	✓
Field-Level Completeness and Accuracy		
% Present	X	—
% Valid	✓	X
Encounter Referential Integrity		
Encounter vs Enrollment	—	
Encounter vs Provider	✓	
Encounter Data Logic		
% of Members Who Had an Encounter	—	—
Member Enrollment Continuity	—	—

MM = Member Months; PMPM = Per Member Per Month; TPL = Third Party Liability

2. Validation of Performance Improvement Projects

Results

SFY 2025 was the third 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 PIHP reported Remeasurement 1 performance indicator results for the CY 2024 (measurement period) PIP validation. The validation results for Magellan's PIP are summarized in Table 2-1 and Table 2-2.

Table 2-1—SFY 2025 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*	No restrictions
	Refinement and changes to strategies to reflect strengths, needs, and plan effectiveness	

Validation Results and Confidence Ratings

Table 2-2 summarizes the SFY 2025 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 2025 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*	33%	100%	*Moderate Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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.

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.

For Table 2-3, gray shaded cells with an — represent data that will be updated in future remeasurement years, and green shaded cells with a + represent any improvement over the baseline results.

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%	N: 1,391 D: 3,221	43.2%+ ▲	— —	—	*Not Assessed*
Refinement and changes to strategies to reflect strengths, needs, and plan effectiveness	N: 580 D: 1,242	46.7%	N: 1,073 D: 2,476	43.3%	— —	—	*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)	• Reconfigure the POC documentation platform for consistent and thorough documentation • Test and implement the updated POC documentation platform across all regions • Provide comprehensive staff training on the new POC documentation platform

Barriers	Interventions
Inconsistent POC evaluation, scoring, and feedback for staff completing the POC	• Standardize the POC scoring process by providing updating guidelines • Revise the POC review tool with clearer definitions and criteria • Conduct targeted training for POC review staff on applying the revised guidelines
Limited number of EBP service providers in the CSoC program	• Contract with new multisystemic therapy (MST) providers • Complete credentialing process for MST providers • Prepare claims system to process MST provider claims and capture data on completed MST provider services

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- The PIHP developed and carried out a methodologically sound PIP design that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The PIHP conducted and reported accurate analyses and interpretation of performance indicator results. **[Quality]**
- The PIHP carried out interventions that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The PIHP collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period. **[Quality]**
- The PIHP's reported Remeasurement 1 results for one (*EBPs are considered when appropriate*) of the two performance indicators demonstrated statistically significant improvement over baseline results. **[Quality, Timeliness, and Access]**

For Magellan, the following opportunity for improvement was identified:

- The PIHP's reported Remeasurement 1 results for one (*Refinement and changes to strategies to reflect strengths, needs, and plan effectiveness*) of the two performance indicators did not demonstrate any improvement over baseline results. **[Quality, Timeliness, and Access]**

For Magellan, the following recommendation was identified:

- To facilitate significant outcomes improvement across all performance indicators, the PIHP should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The PIHP should also revisit barrier analyses for the PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**

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.

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 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 2025 (review period), OBH required Magellan to report five quality management performance measures as part of its QAPI submission. HSAG validated these five performance measures to ensure compliance with technical specifications published by LDH. This section presents the results of HSAG's validation of these quality measures.

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 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 displays 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 Days	HEDIS	*R*	January 1, 2024–December 31, 2024
Follow-Up After Hospitalization for Mental Illness—30 Days			
CANS Outcomes	LDH	*R*	July 1, 2024–June 30, 2025

Performance Measure	Type of Measure	Measure Designation	Reporting Period
Living Situation at Discharge	LDH	*R*	July 1, 2024–June 30, 2025
Improved School Functioning	LDH	*R*	July 1, 2024–June 30, 2025
Utilization of Natural Supports	LDH	*R*	July 1, 2024–June 30, 2025

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 Days	30 Days
MY 2022	69.78%	82.50%
MY 2023*	38.24%	55.61%
MY 2024*	41.52%	59.06%

*The PIHP calculated MY 2023 and 2024 rates on the *Follow-Up After Hospitalization for Mental Illness* measure based on HEDIS specifications but used modified HEDIS specifications to calculate rates for MY 2022. HSAG cannot compare MY 2023 and 2024 rates on this measure to MY 2022 rates.

CANS Outcomes[6]

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

Table 3-3—*CANS Outcomes* Measure Results

Indicator	CY 2023				CY 2024				CY 2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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%	97.45%	98.43%	96.29%	97.46%
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%	54.18%	54.28%	52.07%	51.04%

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

[6] 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.

During CY 2025, the percentage of eligible youth showing improved clinical functioning declined steadily from Quarter 2 to Quarter 4. Compared to previous reporting periods (i.e., CY 2023 and CY 2024), the percentage of youth showing improved clinical functioning declined notably across all four quarters in CY 2025.

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				CY 2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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%	98.85%	99.53%	98.54%	98.78%
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%	96.51%	94.06%	94.10%	93.59%
Percentage of youth discharging to family home	91.32%	93.21%	90.28%	90.32%	95.50%	95.10%	94.50%	92.60%	96.05%	92.39%	93.36%	91.74%
Percentage of youth discharging to foster care	2.63%	1.23%	3.58%	2.05%	2.00%	1.40%	1.10%	1.40%	0.46%	1.66%	0.73%	1.86%
Percentage of youth discharging to inpatient hospital	0.00%	0.62%	1.28%	0.59%	0.10%	0.20%	0.00%	0.20%	0.23%	0.47%	0.24%	0.21%
Percentage of youth discharging to residential placement	4.21%	3.70%	2.30%	4.99%	1.30%	2.10%	2.30%	4.70%	2.08%	3.32%	2.45%	3.31%
Percentage of youth discharging to juvenile justice setting	1.32%	1.23%	2.05%	0.88%	1.00%	1.20%	1.90%	1.20%	0.69%	1.90%	2.45%	2.69%
Percentage of youth discharging to other setting	0.53%	0.00%	0.51%	1.17%	0.00%	0.00%	0.20%	0.00%	0.46%	0.23%	0.73%	0.21%

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 2025, over 90 percent of eligible youth were discharged from the CSoC to an HCB setting or family home, as was the case during the previous reporting periods. The percentage of youth discharged to residential placement during Quarter 4 continued to decline from CY 2023 to CY 2025; however, the

percentage of youth discharged to a juvenile justice setting during Quarter 4 increased steadily from CY 2023 to CY 2025.

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				CY 2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CANS compliance rate	91.05%	95.69%	92.62%	93.86%	70.5%	83.8%	98.2%	99.2%	97.44%	98.43%	95.48%	96.48%
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%	54.44%	49.30%	45.51%	47.25%
Percentage of children with improved school attendance	52.45%	53.78%	53.64%	56.39%	51.9%	64.9%	51.9%	47.7%	54.48%	51.40%	44.16%	53.28%
Percentage of children with improved school behavior	59.21%	53.57%	58.89%	55.92%	52.3%	62.6%	57.6%	47.3%	50.15%	44.49%	44.40%	47.52%

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 2025, the percentages of children showing improved school functioning, improved school attendance, and improved school behavior declined steadily from Quarter 1 to Quarter 3 and rebounded in Quarter 4. Compared to previous reporting periods, the percentages of children showing improved school functioning, school attendance, and school behavior declined notably in Quarter 2 and Quarter 3 of CY 2025.

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 Plan of Care (POC)	CY 2023				CY 2024				CY 2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
All members	89.62%	87.71%	88.38%	88.69%	89.66%	93.0%	93.5%	90.8%	92.10%	94.41%	94.41%	93.40%
Members enrolled 0–90 days	80.40%	79.18%	82.64%	82.24%	80.60%	86.2%	88.8%	82.0%	87.43%	85.61%	86.79%	85.52%
Members enrolled 91–180 days	89.65%	84.96%	82.35%	85.39%	89.66%	90.1%	91.6%	87.4%	86.75%	92.65%	89.50%	88.48%
Members enrolled 181–360 days	90.31%	90.25%	91.49%	90.96%	89.90%	95.0%	96.0%	93.7%	93.80%	96.92%	96.83%	95.61%
Members enrolled 361–540 days	92.53%	91.30%	92.95%	92.41%	93.50%	97.4%	98.1%	97.1%	97.53%	97.34%	99.26%	98.81%
Members enrolled 541+ days	92.08%	91.43%	91.61%	90.78%	92.07%	97.4%	95.1%	96.0%	97.13%	98.87%	99.54%	98.69%

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

Among all members enrolled in the CSoC, the percentage with at least one natural/informal support on their POC steadily increased from CY 2023 to CY 2025. This observation also applies to members enrolled in the CSoC at the specified time intervals.

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- The PIHP improved its performance on the *Follow-Up After Hospitalization for Mental Illness* measure from MY 2023 to MY 2024. The MY 2024 rates on this measure suggest that the PIHP improved care coordination for CSoC enrollees discharged from a hospital and facilitated follow-up care for these members within 30 days of discharge. The PIHP's performance on this measure demonstrates its commitment to ensuring that CSoC members receive needed behavioral healthcare services at home or within their community. **[Quality, Timeliness, and Access]**
- During both CY 2025 and previous reporting periods, over 90 percent of eligible youth were discharged from the CSoC to an HCB setting or family home. Additionally, the percentage of youth discharged to residential placement during Quarter 4 continued to decline from CY 2023 to CY 2025. These results suggest that the PIHP consistently maintained youth in the home and community and avoided out-of-home placement. **[Quality and Access]**
- Among all members enrolled in the CSoC, the percentage with at least one natural/informal support on their POC steadily increased from CY 2023 to CY 2025. This result suggests that the PIHP's care

planning efforts ensured that CSoC members had the necessary support to promote sustained well-being. **[Quality and Access]**

For Magellan, the following opportunities for improvement were identified:

- During CY 2025, there was a steady decline in the percentage of eligible youth showing improved clinical functioning from Quarter 2 to Quarter 4. The decline is observed across all four quarters when compared to CY 2023 and CY 2024. **[Quality and Access]**
- From CY 2023 to CY 2025, there was a steady increase in the percentage of youth discharged to a juvenile justice setting during Quarter 4. **[Quality and Access]**
- Compared to previous reporting periods, there was a notable decline in the percentages of children showing improved school functioning, school attendance, and school behavior during Quarter 2 and Quarter 3 of CY 2025. **[Quality and Access]**

For Magellan, the following recommendations were identified:

- The PIHP's performance on measures that evaluate CSoC members on clinical functioning and school functioning (including school attendance and behavior) declined in CY 2025 compared to previous reporting periods. Additionally, the PIHP saw an increase in the percentage of members discharged to a juvenile justice setting in Quarter 4 of CY 2025 compared to the same period in CY 2023 and CY 2024. HSAG recommends that the PIHP review these trends and conduct analyses to understand the factors that prevent members from improving their clinical and school functioning over time. HSAG also recommends that the PIHP research and address the factors that result in members being discharged to a justice setting 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),[7] 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.

[7] 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 31, 2025.

- **Performance measure reports**—HSAG also reviewed the PIHP's CY 2025 (MY 2024) 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. 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

Table 4-1 presents an overview of the results of the 2025 CR for Magellan. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in the following Methodology section. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards.

Table 4-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Enrollment and Disenrollment Requirements and Limitations	12	5	5	0	7	100%
II	Member Rights and Confidentiality	24	23	23	0	1	100%
III	Member Information	19	16	14	2	3	88%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	11	9	2	4	82%
VI	Coordination and Continuity of Care	12	12	12	0	0	100%
VII	Coverage and Authorization of Services	23	20	18	2	3	90%
VIII	Provider Selection	19	19	11	8	0	58%
IX	Subcontractual Relationships and Delegation	6	0	0	0	6	NA
X	Practice Guidelines	6	6	5	1	0	83%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	31	6	1	84%
XIV	Program Integrity	18	18	16	2	0	89%
Total Compliance Score		**227**	**200**	**177**	**23**	**27**	**89%**

M=*Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The **total** number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

PIHP Strengths, Opportunities for Improvement, Required Actions, and/or Recommendations

For Magellan, the following strengths were identified:

- The PIHP achieved a 100 percent compliance score for Standard I—Enrollment and Disenrollment Requirements and Limitations, demonstrating nondiscriminatory enrollment and contractually compliant disenrollment processes under LDH oversight. **[Quality and Access]**
- The PIHP achieved a 100 percent compliance score for Standard II—Member Rights and Confidentiality, demonstrating appropriate member rights protections, privacy practices, and confidentiality controls consistent with regulatory and contractual requirements. **[Quality and Access]**
- The PIHP achieved a 100 percent compliance score for Standard IV—Emergency and Poststabilization Services, demonstrating that it had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care. **[Quality, Timeliness, and Access]**
- The PIHP achieved a 100 percent compliance score for Standard VI—Coordination and Continuity of Care, demonstrating coordinated and member-centered processes across assessment, planning, information sharing, and access to services. **[Quality, Timeliness, and Access]**
- The PIHP achieved a 100 percent compliance score for XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]**
- The PIHP achieved a 100 percent compliance score for Standard XII—Quality Assessment and Performance Improvement, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; LDH-approved PIPs; and timely reporting to LDH. **[Quality]**

For Magellan, the following opportunities for improvement were identified:

- Magellan's member handbook did not include components that are required by CMS. **[Quality]**
- Magellan's paper and electronic provider directory were missing required components. **[Quality and Access]**
- The case file review results for the PIHP identified noncompliance with evaluating the notices of adverse benefit determination (ABD) for reading grade level. **[Quality]**
- Magellan did not require its network providers meet the State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality, Timeliness, and Access]**
- Magellan's time/distance checklist identified areas of noncompliance. **[Quality and Access]**

- For standard authorization decisions, Magellan's timeliness tracking sheets and the case file review demonstrated noncompliance with timeliness for processing standard authorizations. **[Quality, Timeliness, and Access]**
- Magellan's CR demonstrated low compliance with Standard VIII—Provider Selection (58 percent). **[Quality and Access]**
- Magellan was unable to provide evidence of how it aligned the practice guidelines with utilization management (UM), member education, and coverage of services, and how the guidelines were actually used consistently in decision making per the federal requirement. **[Quality]**
- Magellan did not demonstrate its process for extending the time frame for resolving grievances by up to 14 calendar days if a member requests the extension or if Magellan shows that there is need for additional information and how the delay is in the member's interest. **[Quality and Timeliness]**
- Magellan did not demonstrate its process for extending the time frame for resolving grievances by up to 14 calendar days if a member requests the extension or if Magellan shows that there is need for additional information and how the delay is in the member's interest. **[Quality and Timeliness]**
- Magellan did not require written consent from its members for appeals that are requested by a provider or an authorized representative on behalf of the member. **[Quality]**
- Magellan did not consistently acknowledge receipt of each appeal within required time frames. **[Quality and Timeliness]**
- Magellan did not provide its members with a notice of 120 calendar days from the date of Magellan's notice of appeal resolution to request a State fair hearing (SFH). **[Quality and Timeliness]**
- Magellan's policies and procedures did not include required individuals and entities as parties to the appeal and SFH. **[Quality]**
- Magellan did not implement and maintain arrangements or procedures for notification to LDH when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program. **[Quality and Timeliness]**
- Magellan did not develop a process to execute or terminate network provider agreements pending the outcome of screening, enrollment, and revalidation processes within the required 120-day period. **[Quality and Timeliness]**

For Magellan, the following required actions and/or recommendations were identified:

- Magellan's member handbook must include all components that are required by CMS. **[Quality]**
- Magellan must include required components in its paper and electronic provider directory. **[Quality and Access]**
- The PIHP must ensure that member notifications meet state-required reading levels and that the PIHP's documentation of reading levels for case files is accurately demonstrated. The PIHP should add functionality to the system that houses and tracks prior authorization requests and resolutions so that users may document that notices of ABD include all requirements and indicate that the reading grade level has been verified. **[Quality]**

- Magellan must require its network providers meet the State standards for timely access to care and services, taking into account the urgency of the need for services, including any appointment time metrics defined and chosen by Magellan. **[Quality and Access]**
- Magellan must offer an appropriate range of preventive services that are adequate for the anticipated number of members for the service area and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. **[Quality and Access]**
- Magellan must develop a process for ensuring timely processing of standard authorizations. **[Quality, Timeliness, and Access]**
- Magellan must review Standard VIII—Provider Selection in its CR report and address the noncompliant findings. **[Quality and Access]**
- Magellan must update or develop policies and procedures that demonstrate that decisions for UM, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. **[Quality]**
- Magellan must develop and document a process to extend the time frame for resolving grievances by up to 14 calendar days if a member requests the extension or if Magellan shows that there is need for additional information and how the delay is in the member's interest. **[Quality and Timeliness]**
- Magellan must obtain written consent from its members for appeals that are requested by a provider or an authorized representative on behalf of the members. **[Quality]**
- Magellan must revise its policy and procedure to acknowledge receipt of each appeal in writing within three business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. **[Quality and Timeliness]**
- Magellan must provide its members with a notice of *120 calendar days* from the date of Magellan's notice of appeal resolution to request an SFH. **[Quality and Timeliness]**
- Magellan's policies and procedures must include required individuals and entities as parties to the appeal and SFH. **[Quality]**
- Magellan must implement and maintain arrangements or procedures for notification to LDH when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program. **[Quality and Timeliness]**
- Magellan must develop a process to execute or terminate network provider agreements pending the outcome of screening, enrollment, and revalidation processes within the required 120-day period. **[Quality and Timeliness]**

Methodology

Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the MCEs for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 4-2 outlines the division of standards reviewed in CY 2021, CY 2022, CY 2023, and CY 2024.

Table 4-2—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III—Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓
Standard VII—Coverage and	§438.210	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Authorization of Services											
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§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).
* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection

Prior to beginning the CR, HSAG developed data collection tools, referred to as "CR tools," to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate

the MCEs' compliance were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[8]

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an IS review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

[8] 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 31, 2025.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with the CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, CM, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service authorization denials

from the full universe of records provided by the MCE. HSAG selected 10 records for CM with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE'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.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

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

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE's key staff members. Table 4-3 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 4-3—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025–September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

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 accessibility of 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 accessibility of care and services provided by the PIHP. Table 4-4 depicts assignment of the standards to the domains of care.

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

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment Requirements and Limitations	✓		✓
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	✓	✓	✓

Results

NAV Audit

This section presents the results from the CY 2024 (review period) NAV audit.

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the Information Systems Capabilities Assessment (ISCA) combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCE according to the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[9] Table 5-1 presents a summary of the NAV validation ratings for Magellan by network adequacy standard type.

Table 5-1—Summary of Magellan Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not be Validated
Time and Distance	100%	0%	0%	0%	0%
Access and Availability	100%	0%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of nine indicators for Magellan. Of these indicators, 100 percent received *High Confidence* ratings.

Access Standards

Table 5-2 contains the percentage of members Magellan reported with access at the statewide level, by provider type and by urbanicity. LDH established a 100 percent threshold for Magellan when determining requirements met with distance standards. Results that achieved the 100 percent threshold are shaded in green and marked with an up arrow.

[9] 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 31, 2025.

Table 5-2—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)	100%↑
	Rural (30 miles)	87.8%
Behavioral Health Specialists (psychologists, medical psychologists, APRNs or CNSs, or LCSWs)	Urban (15 miles)	100%↑
	Rural (30 miles)	92.8%
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 of the LDH-established performance goals for appointment access standards. Table 5-3 displays the indicator and achieved compliance rate.

Table 5-3—Magellan Appointment Access Standard Compliance Rates for Behavioral Health

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

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- Magellan maintained effective data integrity controls to ensure the accuracy and completeness of enrollment and claims data stored in the claims adjudication payment system's automated batch processes, reconciliation activities, and error reporting mechanisms supported ongoing validation and correction of data discrepancies. **[Quality]**
- Magellan demonstrated a strong provider data management process supported by its transition from Cactus to SmartCred and integration with Strategic Provider Systems. Data quality was maintained through quarterly provider attestations, ongoing continuous quality improvement audits, and automated system validation reports. Sanctions and exclusions list monitoring continued to occur monthly to ensure network compliance. **[Quality]**

For Magellan, the following opportunity for improvement was identified:

- While Magellan demonstrated comprehensive processes for maintaining, validating, and reporting data across enrollment, provider, and network adequacy systems, opportunities exist to further strengthen documentation traceability and validation transparency to ensure consistency across all data sources used in reporting. **[Quality]**

For Magellan, the following recommendation was identified:

- HSAG recommends that Magellan continue to enhance documentation traceability and validation transparency by ensuring all data validation steps across its claims systems, provider database, and Quest are clearly documented and consistently reviewed. Establishing a standardized process for cross-system validation reviews would further support data integrity and alignment across reporting sources. **[Quality]**

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.

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.

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 5-4.

Table 5-4—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 5-5 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-5—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 5-6.

Table 5-6—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

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

6. Encounter Data Validation

Results

Information Systems Review

Representatives from Magellan completed the LDH-approved questionnaire supplied by HSAG through the Universal Survey Tool (UST). HSAG identified follow-up questions based on Magellan's original questionnaire responses, and Magellan responded to these specific questions. To support its questionnaire responses, Magellan submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from Magellan regarding its encounter data processes.

The administrative profile analyzed LDH's encounter data for completeness, timeliness, and accuracy by evaluating data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of LDH's data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 6-1 provides a list of multifaceted analyses conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of LDH's encounter data from Magellan.

Table 6-1—EDV Results for Magellan

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• Magellan demonstrated its capability to collect, process, and transmit encounter data to LDH, as well as develop data review and correction processes that can respond to quality issues identified by LDH. • Magellan reported methods to identify duplicate claims. • Magellan was responsible for the collection and maintenance of the provider information. In addition, Magellan integrated the Medicaid member enrollment files into its systems for claim processing.
Payment Structures	• Magellan reported pricing methodologies of per diem (69 percent) and line-by-line (31 percent) for professional encounters while using the per diem methodology for all institutional encounters. • Magellan collected and verified TPL information, processed payment based on TPL information, and submitted TPL information to LDH via the encounter data.

Analysis	Key Findings
Encounter Data Quality Monitoring	• Magellan had no subcontractors. Magellan did not perform claim volume, completeness and accuracy, timeliness, or reconciliation with financial reports checks on its professional and institutional encounters. • Based on Magellan's responses to the questionnaire, the percentage of encounters that were initially rejected and not yet accepted by LDH varied from 0.0 percent (institutional encounters) to 19.8 percent (professional encounters).
Administrative Profile	
Encounter Data Completeness	• Magellan displayed relatively consistent encounter volume per 1,000 MM, payment amount PMPM, and TPL payment amount PMPM for professional and institutional encounters throughout the measurement year. • Magellan had a rate of duplicate encounters of less than 1.0 percent for each of the professional and institutional encounter types.
Encounter Data Timeliness	• Within 60 days, Magellan submitted 85.0 percent of the professional encounters and 92.7 percent of the institutional encounters to LDH after the payment date.
Field-Level Completeness and Accuracy	• All key data elements in Magellan's encounter data had a relatively high or reasonable rate of population (i.e., percent of present) except the Referring Provider National Provider Identifier (NPI) and National Drug Code (NDC) fields for Magellan's professional encounters. • Magellan had all key data elements populated with at least 95.0 percent of valid values in the professional encounters while there were two data elements with an accuracy rate below 95.0 percent for the institutional encounters. Refer to the opportunities for improvement section below for the list of data elements needing Magellan's attention.
Encounter Referential Integrity	• No major concerns were noted for Magellan when evaluating the integrity between medical encounters and member enrollment data. • Of all identified provider NPIs in Magellan's submitted medical encounters, 95.8 percent were identified in the provider data.
Encounter Data Logic	• Magellan had 94.9 percent of members with medical encounters throughout the measurement year. • Magellan had 14.1 percent of members who were continuously enrolled in the full measurement year.

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- Magellan had 0.0 percent of institutional encounters classified as initially rejected and not yet accepted by LDH. **[Quality]**
- Magellan had low duplicate rates for professional encounters (0.1 percent) and institutional encounters (0.2 percent). **[Quality]**
- For professional encounters, Magellan had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**
- For referential integrity, Magellan had approximately 95.8 percent of providers in the medical data that were found in the provider data. **[Quality]**

For Magellan, the following opportunities for improvement were identified:

- Magellan did not report claim volume, completeness and accuracy, timeliness, or reconciliation with financial reports checks on encounters collected by Magellan (i.e., non-subcontractor data). **[Quality and Timeliness]**
- Magellan had 19.8 percent of professional encounters classified as encounters initially rejected and not yet accepted by LDH. **[Quality]**
- Magellan only submitted 85.0 percent of professional encounters within 60 days from the payment date. **[Timeliness]**
- The LDH-submitted data did not contain any values for the Referring Provider NPI and NDC fields for Magellan's professional encounters. **[Quality]**
- Magellan had the following data elements with less than 95.0 percent of valid values: **[Quality]**
  - Institutional: *Attending Provider NPI* (84.9 percent) and *Attending Provider Taxonomy Code* (70.0 percent).

For Magellan, the following recommendations were identified:

- Magellan should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of its encounter data. **[Quality and Timeliness]**
- Magellan should build a process with LDH to ensure that rejected professional encounters will be submitted to LDH with correct information. **[Quality]**
- Magellan should monitor its encounter data submission to LDH to ensure professional encounters are submitted to LDH after payment in a timely manner. **[Timeliness]**
- For professional encounters, Magellan should work with LDH to decide whether Magellan should submit values (if any) for the Referring Provider NPI and NDC fields to LDH. **[Quality]**
- Magellan should investigate the root causes for data elements with less than 95.0 percent of valid values (i.e., those listed in the opportunities for improvement section) to improve accuracy. **[Quality]**

Methodology

Objectives

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, LDH requires its contracted Medicaid MCEs to submit high-quality encounter data. LDH relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2024–2025, LDH contracted with HSAG to conduct an EDV study consisting of the following two activities:

- IS review—assessment of LDH's and the MCEs' IS and processes. The goal of this activity was to examine the extent to which LDH's, and the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's [Managed Care Plan's] capability in the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).[10]
- Administrative profile—analysis of LDH's electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the electronic encounter data in LDH's data warehouse are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from January 1, 2023, through December 31, 2023. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

Technical Methods of Data Collection

Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- **Stage 1—Document Review:** HSAG conducted a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by LDH. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, LDH's current encounter data submission requirements, and other relevant materials. The information obtained

[10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 31, 2025.

from this review was important for developing a targeted questionnaire to address important topics of interest to LDH.

- **Stage 2—Development and Fielding of Customized Encounter Data Assessment:** HSAG first evaluated the MCEs' most recent ISCA, if available, to assess whether the information is complete and up to date. This process allowed these activities to be coordinated across projects, preventing duplication, and minimizing the impact on the MCEs. HSAG then developed a questionnaire customized in collaboration with LDH to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, this review included specific topics of interest to LDH. For example, the reviews included questions regarding how MCEs ensure their subcontractors are submitting timely, complete, and accurate encounter data.

  The questionnaire for LDH had similar domains; however, it focused on LDH's data exchange with the MCEs.

  HSAG created a different questionnaire for each MCE program (MCO, PAHP, PIHP) and submitted the appropriate questionnaire to each MCE to collect information. Additionally, since there were nine MCEs included in the study, HSAG distributed the questionnaire via an online tool to streamline collection of the responses.
- **Stage 3—Key Informant Interviews:** After reviewing responses to the questionnaires, HSAG followed up with key LDH and MCE information technology personnel to clarify any questions from the questionnaire responses.

Administrative Profile

HSAG assessed final adjudicated encounters with service dates from January 1, 2023, through December 31, 2023. In addition, the EDV study used member demographic/enrollment data and provider data to evaluate the validity of key data elements in the encounter data. HSAG used the monthly data extracts submitted by LDH's fiscal agent contractor (FAC) between January 2023 and December 2024 for the analysis.

Once HSAG received data files from LDH, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Percentage present—Required data fields were present on the file and had values in those fields.
- Percentage of valid values—The values were as expected (e.g., valid International Classification Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] codes in the diagnosis field).
- Referential integrity checks—Data sources could be joined with each other based on unique identifiers present in both data sources.

Once the final data were received and processed, HSAG conducted a series of analyses for five key metrics listed in the section below.

At a high level, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], 837 Dental [837D], and National Council for Prescription Drug Programs [NCPDP]). HSAG evaluated these metrics at the statewide level and by MCE. If results indicated data quality issue(s), HSAG conducted additional investigations to determine whether the issue was for a specific category of service (e.g., inpatient, nursing facilities), provider type (e.g., vision vendor, non-emergency transportation vendor), sub-population, etc. HSAG documented all noteworthy findings in the aggregate report.

Metrics for Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur): If the number of members remained stable and there were no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month may indicate incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key was based on the *Member ID*, *Rendering Provider NPI*, and *Date of Service* values.
- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each MCE based on the member enrollment data extracted by LDH.
- Paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from a payment perspective.
- Third TPL paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from the TPL payment perspective.
- Percentage of duplicate encounters

Metrics for Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by LDH within 360 days, from the payment date, in 30-day increments: This metric helps LDH to evaluate the extent to which the MCEs are in compliance with LDH's encounter data timeliness requirements (i.e., submit encounters within 30 days of adjudication).
- Claims lag triangle to illustrate the percentage of encounters received by LDH within two calendar months, three months, …, and such from the service month: This metric allows LDH to evaluate how soon LDH may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Metrics for Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters are complete and accurate through the two study indicators described in Table 6-2 for the key data elements listed in Table 6-3. In addition, Table 6-3 shows the criteria HSAG used to evaluate the validity for each data element. These criteria are based on standard reference code sets, or referential integrity checks against member or provider data.

Table 6-2—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table 6-3 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3. The criteria for validity are listed in Table 6-3.

Table 6-3—Key Data Elements for Percent Present and Percent Valid

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Member ID[H]	✓	✓	✓	✓	• In member file • Enrolled in a specific MCE on the date of service
Detail Service From Date[D]	✓	✓	✓		• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date[D]	✓	✓	✓		• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Date of Service[D]				✓	• Date of Service ≤ Paid Date

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Billing Provider National Provider Identifier (NPI)[H]	✓	✓	✓	✓	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider NPI[H]	✓		✓		• In provider data when service occurred • Meets Luhn check digit formula requirements
Attending Provider NPI[H]		✓			• In provider data when service occurred • Meets Luhn check digit formula requirements
Referring Provider NPI[H]	✓	✓	✓		• In provider data when service occurred • Meets Luhn check digit formula requirements
Prescribing Provider NPI				✓	• In provider data when service occurred • Meets Luhn check digit formula requirements
Rendering Provider Taxonomy Code[H]	✓		✓		• In standard taxonomy code set • Matches the value in provider data
Attending Provider Taxonomy Code[H]		✓			• In standard taxonomy code set • Matches the value in provider data

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Primary Diagnosis Codes[H]	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year (e.g., in 2023 code set for services that occurred between October 1, 2022, and September 30, 2023)
Secondary Diagnosis Codes[H]	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Codes/Current Dental Terminology (CDT) Codes[D]	✓	✓	✓		In national CPT, HCPCS, CDT code sets for the correct code year (e.g., in 2023 code set for services that occurred in 2023)
Procedure Code Modifiers[D]	✓	✓			In national standard code set or in the origin and estimation modifier list[11]
Tooth Number[D]			✓		In national standard code set
Tooth Surface[D]			✓		In national standard code set
Oral Cavity Code[D]			✓		In national standard code set
Primary Surgical Procedure Codes[H]		✓			In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes[H]		✓			In national ICD-10-CM surgical procedure code sets for the correct code year

[11] Healthy Louisiana. Medicaid Managed Care Entities System Companion Guide, Version 1, June 18, 2025. Available at: https://ldh.la.gov/assets/medicaid/MCE_System_Companion_Guide/HLA_MCE_SCG_v.1.pdf. Accessed on: Dec 31, 2025.

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Revenue Codes[D]		✓			In national standard revenue code sets for the correct code year
Type of Bill Codes[H]		✓			In national standard type of code set
National Drug Codes (NDCs)[D]	✓	✓		✓	In national NDC code sets
Submit Date[D]	✓	✓	✓	✓	MCE Submission Date (i.e., the date when the MCE submits encounters to LDH) ≥ MCE Paid Date
MCE Paid Date[D]	✓	✓	✓	✓	MCE Submission Date (i.e., the date when MCE submit encounters to LDH) ≥ MCE Paid Date
Detail Paid Amount[D]	✓	✓	✓	✓	Zero or positive
Detail TPL Paid Amount[D]	✓	✓	✓	✓	Zero or positive

[H] Conduct evaluation at the header level.
[D] Conduct evaluation at the detail level.

Metrics for Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that were present in both the encounter data and member enrollment files) through the key study indicators described in Table 6-4. If an encounter contained more than one NPI (e.g., attending provider NPI and billing provider NPI on an institutional encounter), HSAG included both unique NPIs in the analysis.

Table 6-4—Key Indicators of Referential Integrity

Data Source	Indicator
Medical/Dental Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter

Data Source	Indicator
Pharmacy Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Pharmacy Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Pharmacy Encounter
Medical/Dental Encounters vs Pharmacy Encounters	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Also Have a Pharmacy Encounter • Direction 2: Percentage of Members With a Pharmacy Encounter Who Also Have a Medical/Dental Encounter
Medical/Dental Encounters vs Provider File	• Direction 1: Percentage of Providers in the Medical/Dental Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical/Dental Encounter File
Pharmacy Encounters vs Provider File	• Direction 1: Percentage of Providers in the Pharmacy Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File

Metrics for Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG used logic-based checks to ensure the encounter data appropriately support additional activities.

- Percentage of members with a medical encounter, pharmacy encounter, both medical and pharmacy encounters, or neither from January 1, 2023, through December 31, 2023.
- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provided insight into how well encounter data may be used to support future analyses, such as HEDIS performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Description of Data Obtained

Information Systems Review

Representatives from each MCE completed the LDH-approved questionnaire and then submitted their responses and relevant documents via the UST to HSAG for review. Of note, the questionnaire included an attestation statement for each MCE's chief executive officer or responsible individual to certify that the information provided was complete and accurate.

Administrative Profile

Data obtained from LDH included:

- Claims and encounter data with dates of service from January 1, 2023, through December 31, 2023.
- Member demographic and enrollment data.
- Provider data.

How Data Were Aggregated and Analyzed

Information Systems Review

Questionnaire responses were collected and stored in a secure database maintained by HSAG. HSAG compiled responses from the received LDH- and MCE-specific questionnaires and assembled the information in Microsoft Excel workbooks. Responses were analyzed based on their relationship to the IS review EDV measures.

Administrative Profile

After consultation with LDH, HSAG used the data tables provided by LDH to create encounter, member demographic, member enrollment, and provider data files that contained the variables necessary for analysis. To analyze the data, HSAG prepared charts and figures to evaluate the pre-determined study metrics.

How Conclusions Were Drawn

Information Systems Review

HSAG made conclusions based on the CMS EQR Protocol 5, the MCE contracts, LDH's current encounter data submission requirements (e.g., companion guides), and HSAG's historical experience working with other states regarding the IS review.

Administrative Profile

To draw conclusions about the quality of each MCE's encounter data submissions to LDH, HSAG evaluated the results based on the predefined study and/or key metrics described above. To identify strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the MCEs' encounter data submissions to LDH. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to LDH.

Table 6-5—Assignment of EDV Measure Activities to the Quality, Timeliness, and Access Domains

EDV Measure	Quality	Timeliness	Access
IS Review: Encounter Data Sources and Systems	✓	✓	
IS Review: Payment Structures	✓	✓	
IS Review: Encounter Data Quality Monitoring	✓	✓	
Administrative Profile: Encounter Data Completeness	✓		
Administrative Profile: Encounter Data Timeliness		✓	
Administrative Profile: Encounter Data Accuracy: Field-level Completeness and Accuracy	✓		
Administrative Profile: Encounter Data Referential Integrity	✓		
Administrative Profile: Encounter Data Logic	✓		

7. PIHP Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2025 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 7-1 through Table 7-3.

Table 7-1—Strengths Related to Quality, Timeliness, and Access

Overall PIHP Strengths	
PIP	• Magellan developed and carried out a methodologically sound PIP design that facilitated valid and reliable measurement of objective indicator performance over time; conducted and reported accurate analyses and interpretation of performance indicator results; and carried out interventions that had the potential to address identified barriers and improve performance indicator results. **[Quality]** • Magellan collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period. **[Quality]** • Magellan's reported Remeasurement 1 results for one (*EBPs are considered when appropriate*) of the two performance indicators demonstrated statistically significant improvement over baseline results. **[Quality, Timeliness, and Access]**
PMV	• Magellan improved care coordination for CSoC enrollees discharged from a hospital and facilitated follow-up care for these members within 30 days of discharge. **[Quality, Timeliness, and Access]** • During both CY 2025 and previous reporting periods, over 90 percent of eligible youth were discharged from the CSoC to an HCB setting or family home and the percentage of youth discharged to residential placement during Quarter 4 continued to decline, suggesting that Magellan consistently maintained youth in the home and community and avoided out-of-home placement. **[Quality and Access]** • Magellan's care planning efforts ensured that CSoC members had the necessary support to promote sustained well-being. **[Quality and Access]**
Compliance	• The PIHP scored 100 percent for six standards in the CR, indicating that the PIHP's policies and procedures were generally compliant with contract requirements, and staff were generally knowledgeable about the requirements, policies, and procedures. **[Quality, Timeliness, and Access]**
NAV	• Magellan maintained effective data integrity controls to ensure the accuracy and completeness of enrollment and claims data stored in its claim adjudication and payment system. **[Quality]** • Magellan demonstrated a strong provider data management process supported by its transition from Cactus to SmartCred and integration with Strategic Provider Systems. Data quality was maintained through quarterly provider attestations, ongoing continuous quality improvement audits, and automated system validation reports. Sanctions and exclusions list monitoring continued to occur monthly to ensure network compliance. **[Quality]**

Overall PIHP Strengths	
EDV	• Magellan had 0.0 percent of institutional encounters classified as initially rejected and not yet accepted by LDH. **[Quality]** • Magellan had low duplicate rates for professional encounters (0.1 percent) and institutional encounters (0.2 percent), and for professional encounters, Magellan had all key data elements populated with at least 95.0 percent of valid values. **[Quality]** • For referential integrity, Magellan had approximately 95.8 percent of providers in the medical data that were found in the provider data. **[Quality]**

Table 7-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall PIHP Opportunities for Improvement	
PIP	• The PIHP's reported Remeasurement 1 results for one (*Refinement and changes to strategies to reflect strengths, needs, and plan effectiveness*) of the two performance indicators did not demonstrate any improvement over baseline results. **[Quality, Timeliness, and Access]**
PMV	• During CY 2025, there was a steady decline in the percentage of eligible youth showing improved clinical functioning from Quarter 2 to Quarter 4. **[Quality and Access]** • From CY 2023 to CY 2025, there was a steady increase in the percentage of youth discharged to a juvenile justice setting during Quarter 4. **[Quality and Access]** • Compared to previous reporting periods, there was a notable decline in the percentages of children showing improved school functioning, school attendance, and school behavior. **[Quality and Access]**
Compliance	• Magellan scored 32 percent for Standard VIII—Provider Selection, demonstrating the need to improve credentialing and recredentialing processes. **[Quality]**
NAV	• Opportunities existed to further strengthen documentation traceability and validation transparency to ensure consistency across all data sources used in reporting. **[Quality]**
EDV	• Magellan did not report claim volume, completeness and accuracy, timeliness, or reconciliation with financial reports checks on encounters collected by Magellan. **[Quality and Timeliness]** • Magellan had 19.8 percent of professional encounters classified as encounters initially rejected and not yet accepted by LDH. **[Quality]** • The LDH-submitted data did not contain any values for the Referring Provider NPI and NDC fields for Magellan's professional encounters. **[Quality]** • Magellan only submitted 85.0 percent of professional encounters within 60 days from the payment date. **[Timeliness]** • Magellan had two data elements with less than 95.0 percent of valid values. **[Quality]**

Table 7-3—Recommendations

Overall PIHP Recommendations		
EQR Activities	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
PIP	• To facilitate significant outcomes improvement across all performance indicators, the PIHP should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The PIHP should also revisit barrier analyses for the PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**	Goal 4: Promote wellness and prevention
PMV	• HSAG recommends that Magellan review declining trends and conduct analyses to understand the factors that prevent members from improving their clinical and school functioning over time. HSAG also recommends that Magellan research and address the factors that result in members being discharged to a justice setting in Quarter 4. **[Quality and Access]**	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
Compliance	• Magellan must ensure its credentialing and recredentialing processes comply with State and federal requirements. **[Quality]** • Magellan must complete its CAP to resolve all *Not Met* findings from the CR. **[Quality, Timeliness, and Access]**	Goal 1: Ensure access to care to meet enrollee needs Goal 3: Facilitate patient-centered, whole-person care Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
NAV	• HSAG recommends that Magellan continue to enhance documentation traceability and validation transparency by ensuring all data validation steps across its claims systems, provider database, and Quest are clearly documented and consistently reviewed. Establishing a standardized process for cross-system validation reviews would further support data integrity and alignment across reporting sources. **[Quality]**	Goal 1: Ensure access to care to meet enrollee needs

Overall PIHP Recommendations		
EQR Activities	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
EDV	• Magellan should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of its encounter data. **[Quality and Timeliness]** • Magellan should build a process with LDH to ensure that rejected professional encounters will be submitted to LDH with correct information. **[Quality]** • Magellan should monitor its encounter data submission to LDH to ensure professional encounters are submitted to LDH after payment in a timely manner. **[Timeliness]** • For professional encounters, Magellan should work with LDH to decide whether Magellan should submit values (if any) for the Referring Provider NPI and NDC fields to LDH. **[Quality]** • Magellan should investigate the root causes for data elements with less than 95.0 percent of valid values. **[Quality]**	Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending

8. Follow-Up on Prior Year's Recommendations

Table 8-1 through Table 8-4 contain a summary of the follow-up actions that Magellan completed in response to the EQRO's SFY 2024 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 8-1—Follow-Up on Prior Year's Recommendations for PIPs

Recommendation
None identified.

Table 8-2—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendation
HSAG recommended the PIHP to 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.
Response
Describe initiatives implemented based on recommendations: Magellan reviewed the measures that declined in late CY 2024 and identified Level of Care Timeliness (LOC 02: Timely Evaluation) and Plan of Care Timeliness (POC 04: Timely Update of the Plan of Care) as the primary areas needing focused intervention. These measures were prioritized because they are essential to programmatic enrollment and timely access to services. LOC 02 confirms ongoing clinical eligibility and identifies the needs addressed in the care plan, and POC 04 ensures that Plans of Care remain current, reflect changing needs, and support authorization of required services. Magellan conducted a comprehensive review that included trend analysis, documentation audits, and provider feedback. Quality Improvement Projects for LOC 02 and POC 04 were implemented in early 2025. Interventions included the development of standardized tracking logs, automated compliance reports, targeted corrective action plans, and statewide training focused on documentation expectations and timeliness requirements. Monthly validation began in Quarter 2 (Q2) 2025, and both measures were incorporated into the Quality Improvement Committee's monitoring structure.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Performance improved steadily through Quarter 3 (Q3) 2025. • POC 04: Increased from 76.3 percent in Q4 2024 to 77.5 percent in Q1 2025, 79.8 percent in Q2 2025, and 81.2 percent in Q3 2025. • LOC 02: Increased from 88.5 percent in Q4 2024 to 91.8 percent in Q1 2025, 93.2 percent in Q2 2025, and 94.0 percent in Q3 2025.

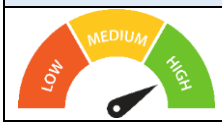
These results reflect sustained and incremental improvement following implementation of the QIPs.
Identify any barriers to implementing initiatives: Barriers included staffing turnover among Wraparound Agencies, varied documentation proficiency, delays associated with transition to the Opeeka P-CIS platform, and early data-integration lag that limited real-time visibility.
Identify strategy for continued improvement or overcoming identified barriers: Magellan will continue to strengthen timeliness through several initiatives introduced in Quarter 3 and early Quarter 4 of 2025. These efforts address the factors that contributed to the decline in late CY 2024 and are intended to improve documentation timeliness, enhance communication with families and providers, and support consistent statewide performance. Manual notification letters, finalized in September and implemented on October 1, 2025, are now sent routinely within two months of a member's waiver expiration date. These letters provide early reminders of reassessments and Plan of Care due dates and help reduce delays associated with documentation issues or system transitions. Weekly meetings with Wraparound Agencies were also established to review outstanding evaluations and Plans of Care. These meetings allow staff to identify workflow barriers, clarify expectations, and resolve issues before deadlines. As agencies have adjusted to this structure, statewide compliance has increased and pending remediation has decreased, indicating that real-time engagement is improving timeliness. Magellan is also implementing system-level network restructuring following the Request for Applications process completed in October 2025. The updated network will consolidate existing Wraparound Agencies and add two new organizations to improve capacity and align resources with performance requirements. A dedicated Project Manager is overseeing the transition, including de-implementation for outgoing agencies and onboarding for new agencies. New contracts are scheduled to begin on April 1, 2026. These combined strategies are expected to support sustained improvement in the timely completion of evaluations and Plans of Care and reduce the likelihood of future declines in performance.
HSAG Assessment


Table 8-3—Follow-Up on Prior Year's Recommendations for Compliance With Medicaid Managed Care Regulations

Recommendation
A CR was not conducted last year; therefore, HSAG did not have prior year recommendations.

Table 8-4—Follow-Up on Prior Year's Recommendations for Network Adequacy

Recommendation
None identified.

Table 8-5—Follow-Up on Prior Year's Recommendations for EDV

Recommendation
Encounter data validation was a new activity; therefore, HSAG did not have prior year recommendations.

Appendix A. PIHP Response to the Health Disparities Questionnaire

PIHP Verbatim Response to HSAG's Health Disparities Questionnaire[12]

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 July1, 2024, through June 30, 2025:

> *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)?*

[12] Please note that the narrative within the PIHP Response to the Health Disparities Questionnaire section was provided by the PIHP and has not been altered by HSAG except for formatting.

Addressing Behavioral Health Disparities: Magellan's Initiatives and Achievements in the Coordinated System of Care (CSoC) Program

Fiscal Year 2025

Program Context and Equity Framework

The Louisiana Coordinated System of Care (CSoC) functions as both a waiver-based program and a structural equity intervention aimed at expanding access to behavioral-health services for high-need youth who have historically faced the greatest barriers. Through a statewide network of Wraparound Agencies (WAAs), Family Support Organizations, and community providers, CSoC provides intensive care coordination and home- and community-based services to youth ages 5 to 20 who meet clinical and functional criteria for serious emotional disturbance. The program serves a small but highly complex group—about 2,900 youth at any time, with 4,283 unique members served in CY 2024. This reflects a 13.2 percent increase from 3,785 in CY 2023 within Louisiana's larger Medicaid population of over one million children. The program's mission is fundamentally equity-driven: to keep youth safely in their homes and communities rather than in restrictive or institutional settings. By design, CSoC offers specialized supports to families facing poverty, limited transportation, fragmented service systems, and other social factors that disproportionately impact access and outcomes (see Appendix A: Data Sources).

CSoC's health-equity strategy aligns with federal expectations that managed-care entities identify and address gaps in health outcomes, health status, and quality of care among Medicaid populations. The program's structure advances this mandate through equitable access to evidence-based Wraparound services, culturally competent care coordination, and continuous monitoring of disparities across regions and subpopulations. Enrollment growth in 2024 was observed across all quarters, ranging from 1,982 in Q1 to 2,239 in Q4, confirming stable participation despite regional workforce constraints. Health equity in CSoC is achieved through the integrity and fidelity of its model, ensuring that every youth, regardless of geography or circumstance, receives the same high-quality, family-driven support.

Population Overview

CSoC's enrolled population represents the intersection of Louisiana's highest behavioral-health needs and its most underserved communities. Demographic and geographic analyses show that enrollment remains predominantly rural and majority African American, with balanced gender representation and increasing regional participation in historically lower-access areas. In CY 2024, 72.6 percent (N = 3,109) of members resided in rural areas and 26.8 percent (N = 1,148) in urban or suburban areas, compared to 74.9 percent (N = 2,835) and 24.4 percent (N = 922) in CY 2023. These patterns demonstrate that CSoC continues to meet its core equity goal of reaching youth who are most at risk for system involvement, school failure, and out-of-home placement. Because any individual with family consent may initiate a referral, the program minimizes procedural barriers to entry and ensures that eligibility is determined by clinical need rather than socioeconomic status.

Regional monitoring allows Magellan to evaluate how equitably services are distributed across Louisiana's nine administrative regions. In 2024, Region 9 accounted for 19.47 percent of enrollment, a decrease of 2.19

percentage points from 2023 (21.66 percent), while Region 2 increased by 2.70 percentage points. Region 6 remained the lowest at 5.65 percent. The program's persistent rural majority underscores both progress and challenge: CSoC has successfully reached areas with limited behavioral-health infrastructure, yet these same regions continue to face provider shortages that may delay service initiation. Ongoing equity efforts, therefore, focus on aligning network development, WAA staffing, and training resources with regional demand.

Magellan conducts an annual population-level equity assessment across the CSoC program to identify any variations in access, timeliness, or quality by race, gender, region, or other risk factors. In 2024, male youth accounted for 56.7 percent of the population, up from 55.9 percent in 2023. Black or African American youth accounted for 52.1 percent (51.7 percent in 2023), while White youth represented 41.7 percent, a decrease of 2.5 percentage points from 2023. Non-Hispanic or Non-Latino members comprised 95.1 percent of enrollees, with Hispanic or Latino members at 0.4 percent and Unknown at 4.5 percent. While analyses show no statistically significant disparities by language or satisfaction, continuous monitoring helps detect emerging barriers early. English remained the primary language for 99.2 percent of members in 2024, compared to 99.3 percent in 2023, while Spanish-speaking members declined slightly to 0.3 percent. Equity priorities remain focused on areas where measurable differences persist, such as regional access to services and Plan of Care timeliness. Member experience data, regional feedback, and Wraparound fidelity reviews provide the qualitative foundation for these ongoing efforts, ensuring that member voice remains central to identifying and addressing disparities.

(See Appendix A for supporting data sources, tables, and performance metrics.)

Process Equity

CSoC's equity strategy for this review period emphasizes process integrity—ensuring that every youth and family receives high-quality, culturally responsive Wraparound care across all regions and provider organizations. In 2024, Louisiana finalized the Louisiana Wraparound Model of Care in collaboration with OBH and Wraparound Agencies (WAAs), aligning contracts, coaching, and training under a unified statewide framework. This standardization was paired with an expanded review cadence and the reinstatement of comprehensive Plan of Care (POC) reviews, producing a substantially larger fidelity sample while maintaining high compliance with established practice standards (see Appendix A, Table A-4). Together, these actions function as a direct equity intervention by reducing variation in practice, strengthening consistency in team-based planning, and ensuring that outcomes are determined by need and engagement rather than geography, staffing patterns, or organizational structure.

Fidelity results from 2024 demonstrate sustained adherence to National Wraparound Initiative (NWI) standards across all core domains, including Family Voice and Choice, Strength-Driven Planning, Needs-Based Alignment with CANS/IBHA, Outcomes-Based Decision-Making, Natural and Community Supports, and Effective Teamwork. Average compliance across 24 fidelity indicators was 97.9 percent, with all 24 meeting or exceeding the 80-percent benchmark and 23 (95.8 percent) surpassing 90 percent. Sixteen items (66.7 percent) achieved compliance at or above 98 percent. Items related to safety planning, mission clarity, and data-driven decision-making continued to perform strongest, with safety concerns addressed in 100 percent of POCs, team mission achieved in 99.8 percent, and plans confirmed as data-driven in 99.7 percent.

Where variation remained—most notably in documenting actionable strategies for informal and natural supports—CSoC analyzed the pattern in relation to enrollment trends following the end of the Public Health Emergency. Shorter enrollment durations were associated with lower rates of documented informal supports early in care. The fidelity item "Informal/natural supports have strategies" recorded 84.9 percent compliance in 2024, a 2.4-percentage-point decrease from 87.3 percent in 2023. Stratified analysis confirmed lower rates

among youth enrolled for fewer than 90 days (82.0–88.8 percent) and higher rates among those enrolled for longer than 180 days (93.7–98.9 percent). These findings will guide targeted coaching and supervisory focus within the new model while accounting for external factors influencing early engagement.

Implementation of the Louisiana Training and Coaching Model operationalizes these fidelity priorities statewide. By consolidating training materials, coaching expectations, and WAA contract language, CSoC has established a uniform foundation for practice. All WAAs initiated OBH-approved coaching practices by the end of CY 2024, with statewide training scheduled for launch in April 2025. OBH-approved materials and certification tools are maintained within the Louisiana Model of Care repository. This alignment is expected to sustain high performance on fidelity indicators already meeting benchmarks and to strengthen areas identified for improvement in 2024, particularly those involving natural-support strategies as enrollment stabilizes. In 2025, administration of the WFI-EZ will re-establish a formal fidelity baseline for the Louisiana model and provide structured feedback from youth, caregivers, and facilitators to inform ongoing coaching priorities.

The Louisiana Wraparound Model of Care serves as both a structured training curriculum and a continuous coaching framework that reinforces adherence to Wraparound principles. Implementation began in February 2024 with phased milestones through 2025, aligning with the adoption of revised POC procedures, LMHP and MST guidance, and updated documentation standards (see Appendix A, Table A-5). The model addresses barriers identified through prior evaluations, including inconsistent facilitator understanding of evidence-based practices, variability in supervision, and limited family engagement. All training, coaching, and evaluation activities are aligned within a single accountability system that incorporates cultural and linguistic responsiveness. Training materials and supervision methods are designed to reflect Louisiana's diverse populations. The Louisiana Wraparound Model of Care is a statewide competency-building system that integrates learning, coaching, and fidelity monitoring to ensure equitable, high-quality Wraparound delivery across all regions and providers.

(See Appendix B for supporting data sources, tables, and performance metrics.)

Infrastructure for Equity Measurement

To support equitable care delivery at scale, CSoC has strengthened the systems that make equity both measurable and actionable. The Person-Centered Intelligence System (P-CIS) was configured to support assessment and care-planning workflows, including embedded risk screening and the electronic submission of CANS. Implementation in 2024 included reconfiguration of the Plan of Care (POC) and Integrated Behavioral Health Assessment (IBHA) modules to capture behavioral health service histories, barriers, strengths, and evidence-based practice (EBP) selection. Structured data fields require documentation of service type, amount, frequency, duration, and alignment to identified needs, enabling consistent measurement of practice fidelity and outcomes across providers and regions.

This modernization enabled near-universal CANS documentation at discharge and improved the reliability of fidelity and outcomes monitoring. In CY 2024, Indicator 1 (EBPs documented in the POC) reached 43.2 percent (1,391 of 3,221), an increase of 6.4 percentage points from the CY 2023 baseline of 36.8 percent (682 of 1,864). Quarterly performance rose steadily from 21.6 percent in Q1 to 64.0 percent in Q4. Indicator 2 (Plan refinement to address strengths, needs, and effectiveness) achieved 43.3 percent (1,073 of 2,476) in CY 2024, with late-year improvement from 26.0 percent in Q1 to 61.3 percent in Q4. Complementary workforce and training infrastructure, including expanded use of the Reach 360 learning system, provides consistent access to curricula and participation tracking for Wraparound Agencies (WAAs) and Family Support Organization staff, reinforcing statewide training parity and coaching accountability under the Louisiana Model of Care.

Administrative fairness remains a core dimension of equity and is reflected in CSoC's performance on grievance and appeal timeliness, documentation compliance, and waiver-assurance measures. All member grievances (N = 12 in 2024) were acknowledged and resolved within required timeframes, with 100 percent compliance for acknowledgment within three business days and resolution within 30 calendar days. Standard appeal acknowledgment timeliness improved from 92.6 percent (N = 54) in 2023 to 97.8 percent (N = 45) in 2024, while resolution timeliness increased from 98.2 percent to 100 percent. Expedited appeals achieved full compliance at 100 percent in 2024, an increase of 1.7 percentage points from 98.3 percent in 2023. Standardized processes and monitoring ensure that members receive timely notices, resolution letters, and service coordination across all regions and providers. Where process gaps were identified, such as during transitions to discharge or in documentation timeliness, CSoC implemented targeted performance-based payments and clarified workflow expectations to reduce variation and protect continuity of care. Waiver-assurance compliance for the Home and Community-Based Settings (HCBS) Rule remained above 99.7 percent throughout 2023 and 2024, confirming continued adherence to federal requirements.

CSoC's technology modernization, coupled with standardized training and monitoring frameworks, provides the infrastructure needed for sustained equity measurement. The 2024 member-experience survey achieved an 84.9 percent response rate (309 of 364), representing a 4.5-percentage-point increase from 2023 (80.4 percent). Overall satisfaction remained high at 89.7 percent, with neutral responses at 8.0 percent and negative responses at 2.3 percent. These quantitative measures, supported by the enhanced capabilities of P-CIS and standardized workflows, enable the program to assess administrative fairness, detect variation across populations and regions, and ensure that members experience timely, consistent, and equitable care coordination statewide.

(See Appendix C for supporting data sources, tables, and performance metrics.)

Outcome Equity

CSoC monitors equity in outcomes by evaluating changes between initial and discharge assessments in Social Determinants of Health (SDOH) items and strengths within the CANS. For CY 2024 discharges with both intake and discharge assessments (N = 1,673), measurable reductions were observed across all domains. The program continued to show a decline in the prevalence of actionable needs, with the most substantial improvements in caregiver family stress, school functioning, and adjustment to trauma. Protective strengths, including resiliency, optimism, educational collaboration, talents and interests, and caregiver knowledge, also demonstrated meaningful gains during program participation. These results reflect the Wraparound model's core focus on team-based planning, family engagement, and the connection of youth and caregivers to community-based supports.

Quantitative analysis confirmed improvement across every SDOH domain from intake to discharge. Family stress decreased by 26.1 percentage points and school functioning by 15.7 percentage points, representing the largest reductions in actionable needs statewide. Moderate but steady gains were also observed in adjustment to trauma (–11.8 ppt), optimism (–10.6 ppt), and caregiver knowledge (–11.2 ppt). Smaller yet meaningful improvements in social resources, resiliency, educational strengths, and talents and interests indicate broader progress in social stability and personal growth.

Complementary service-utilization trends reinforce these outcome gains. The proportion of CSoC youth receiving any outpatient service increased from 63.4% in CY 2023 to 67.6% in CY 2024, a 4.2-percentage-point rise. Traditional outpatient therapy (LMHP) utilization rose from 33.3% to 38.3% (+5.0 ppt), parent support and training from 36.9% to 40.6% (+3.7 ppt), short-term respite from 14.8% to 18.1% (+3.3 ppt), and youth support and training from 24.1% to 26.6% (+2.5 ppt). Together, these data demonstrate that system-level interventions

such as network expansion, performance-based payments, and the addition of new evidence-based services (MST and DBT) have increased service access and supported the functional progress documented in CANS outcomes. CSoC views these results as clear evidence that equitable processes—consistent fidelity to the Wraparound model, culturally responsive planning, and expanded home- and community-based services—produce measurable improvements in the social and environmental factors most closely linked to behavioral health disparities. Member-experience data further support these findings. In 2024, 76.3% of respondents reported receiving services as soon as needed (+2.8 ppt), and 86.97% indicated that services were available at convenient times (–2.2 ppt). As the program's data infrastructure continues to evolve, these baseline reductions in actionable needs and improvements in access will provide a foundation for ongoing stratified equity analysis.

(See Appendix D for supporting data sources, tables, and performance metrics.)

Member Experience and Voice

Member voice remains central to CSoC's improvement strategy. In CY 2024, the Member Satisfaction Survey achieved an 84.9% response rate (309 of 364), a 4.5-percentage-point increase from 2023 (80.4%). Overall satisfaction remained high at 89.7%, with 8.0% neutral and 2.3% negative responses. The highest ratings were observed in cultural and language respect, Wraparound engagement, and caregiver support in managing the child's health. Items related to access and timeliness showed modest year-over-year improvement but continue to be priority areas for ongoing intervention. These findings are consistent with open-ended survey feedback emphasizing facilitator engagement, crisis responsiveness, and remaining barriers related to service initiation, provider stability, and communication.

The grievance process serves as a second structured channel for member input. Total substantiated grievances declined from seven in 2023 to five in 2024. Wraparound Agency grievances decreased from four to three, Waiver Service Provider grievances fell from three to none, and Inpatient Facility grievances increased from none to two. All grievances were acknowledged and resolved within required timeframes, reflecting 100% compliance for both acknowledgment within three business days and resolution within thirty calendar days. Each substantiated case resulted in corrective action or provider retraining consistent with the Louisiana Model of Care. Appeal performance also improved, with standard acknowledgment timeliness increasing from 92.6% (N = 54) in 2023 to 97.8% (N = 45) in 2024, and resolution timeliness rising from 98.2% to 100%. Expedited appeals achieved 100% timely resolution in 2024, a 1.7-percentage-point increase from 98.3% in 2023.

Performance-based payments were implemented to encourage timely submission of Plans of Care and discharge notifications, addressing the transition points most frequently identified in family feedback. Performance data for 2024 show that Plan of Care submission timeliness improved from 28.0% in Q1 to 33.4% in Q2 and 32.9% in July. Discharge notification timeliness increased from 81.0% in Q1 to 92.4% in Q3, with four regions—Regions 4, 5, 7, and 9—meeting the 95% target during Q3. These administrative gains directly respond to member concerns regarding timeliness and continuity of care. In parallel, Magellan expanded behavioral health service options by implementing Mobile Crisis Response, Multisystemic Therapy (MST), and Dialectical Behavior Therapy (DBT) and by removing prior authorization requirements for psychological testing to reduce access barriers.

Member feedback further demonstrates how these improvements translate into equity and satisfaction. Respondents consistently commended Wraparound Facilitators for their communication, follow-up, and cultural responsiveness, while noting the need for continued investment in provider stability and timeliness of services. Among quantitative items linked to outcomes in Section 5, 76.3% of members reported receiving services as soon as needed, and 86.97% confirmed service availability at convenient times. These findings mirror the reductions observed in CANS measures for school functioning needs (–15.7 percentage points) and family stress (–26.1

percentage points). Together, the satisfaction and outcome data indicate that improvements in administrative fairness and provider capacity are producing measurable benefits for CSoC members.

(See Appendix E for supporting data sources, tables, and performance metrics.)

Equity Governance and Continuous Improvement

CSoC's approach to health equity is fully integrated within its quality governance framework. Oversight is provided through the Quality Improvement Committee (QIC), the Quality of Care Concerns (QOCC) Workgroup, and subcommittees aligned with waiver assurance and utilization management. Together, these bodies ensure that program fidelity, service access, and member protections are monitored, evaluated, and corrected within the same continuous improvement structure that governs all quality indicators. Equity is embedded through accountability rather than treated as a separate initiative; each review, corrective action, and policy revision carries the expectation that every youth and family will experience the same high-quality, person-centered standard of care.

During 2023–2024, these governance structures reviewed all quality-of-care investigations, performance measures, and quarterly waiver indicators, confirming consistently high compliance in administrative fairness metrics. Waiver-assurance monitoring under the Home and Community-Based Services (HCBS) Settings Rule remained above 99.7% each quarter, with rates ranging from 99.78% to 99.96%. Utilization management results reflected overall program stability, with inpatient admissions essentially unchanged—172 in 2023 compared to 173 in 2024. The percentage of youth experiencing an inpatient stay increased slightly by 0.8 percentage points, from 6.5% to 7.3%. Readmission rates showed improvement, declining from 19.1% in the third quarter of 2023 to 15.8% in the third quarter of 2024. The average length of stay decreased from 408.8 days in 2023 to 398.7 days in 2024, a reduction of 10.1 days. These indicators demonstrate that the governance processes continue to function effectively by identifying variation, initiating corrective actions, and sustaining strong compliance across core measures.

CSoC applies the same equity lens to provider oversight. Quality-of-care investigations, performance-based contracting, and utilization reviews are stratified by region and provider type to identify any disproportionate findings that may indicate systemic variation. In 2024, the QOCC reviewed all substantiated grievances (N = 5) and verified that corrective actions or retraining were completed within the required timeframes in 100% of cases. When differences are identified, corrective actions are paired with coaching or policy clarification rather than punitive measures, reinforcing a culture of improvement over sanction. This consistent structure promotes equity not only for members but also across the provider network, ensuring that expectations and supports are applied uniformly throughout the state.

(See Appendix F for supporting data sources, tables, and performance metrics.)

Quality Improvement Goals and Forward Priorities

CSoC's quality improvement priorities for 2025 continue to advance equity through the consistent implementation of the Louisiana Wraparound Model of Care, expansion of service access, and reinforcement of workforce competencies. Each initiative is integrated into the QAPI framework and monitored by established committees to ensure that progress toward equity remains measurable and sustainable.

Access and Service Capacity

Improving access remains a central priority. Between CY 2023 and 2024, the proportion of youth receiving any outpatient service increased by 4.2 percentage points, from 63.4% to 67.6%. Utilization of Licensed Mental Health

Professional (LMHP) services rose by 5.0 points, from 33.3% to 38.3%. Parent Support and Training increased by 3.7 points, from 36.9% to 40.6%, while Short-Term Respite rose by 3.3 points, from 14.8% to 18.1%. In 2025, CSoC will continue expanding the number of behavioral health and home- and community-based service providers across all regions, with targeted efforts focused on LMHPs and provisional LMHPs. Growth in provider participation will be monitored through quarterly network adequacy reviews and GEO analyses to verify equitable service distribution across the state. Collaboration with LDH will ensure that network expansion aligns with documented regional needs and supports timely access to clinical and support services.

Workforce Competency and Fidelity

The implementation of the Louisiana Training and Coaching Model will serve as the foundation for workforce development. All new Wraparound staff hired after April 2025 will be trained using the standardized curriculum, promoting consistent practice expectations and fidelity across regions. Coaching supervision, delivered under the approved OBH model, will focus on reinforcing strengths-based planning, cultural responsiveness, and effective teaming—core elements of process equity. Statewide use of the Reach 360 learning platform in 2024 recorded completion of five required training modules per participant and maintained attendance documentation for all WAAs and FSOs. These tools promote equitable access to learning opportunities and strengthen accountability for staff development across the system.

Member Experience and Service Timeliness

CSoC will continue monitoring and improving the timeliness of Plan of Care submissions, reassessments, and discharge notifications. In 2024, Plan of Care submission timeliness improved from 28.0% in Q1 to 33.4% in Q2 and 32.9% in July. Discharge notification timeliness increased from 81.0% in Q1 to 92.4% in Q3, with four regions meeting the 95% target by the end of Q3. These indicators are central to ensuring continuity of care and preventing service disruptions that disproportionately affect families facing systemic barriers. Annual Member Satisfaction Surveys and grievance analyses will supplement quantitative monitoring, providing critical feedback to guide ongoing training and policy adjustments.

Outcomes and Data Integration

In 2025, CSoC will resume administration of the Wraparound Fidelity Index – Short Form (WFI-EZ) to establish baseline fidelity data under the new model and strengthen the program's outcome measurement infrastructure. CANS outcomes from 2024 demonstrated a 26.1-point reduction in family stress needs, a 15.7-point improvement in school functioning, and consistent gains across resiliency and trauma adjustment domains. Data from the WFI-EZ, CANS, and service utilization reports will be integrated within the P-CIS platform to enhance visibility of outcome trends and enable future stratification by key demographic characteristics. This integrated approach supports the continuous identification of disparities in functioning, satisfaction, and service utilization while guiding targeted improvement initiatives.

System Stewardship and Accountability

CSoC will maintain a strong focus on provider oversight, timely completion of corrective actions, and transparent reporting through the QIC and its subcommittees. Quarterly HCBS Settings Rule compliance averaged 99.8% in 2024. Inpatient readmissions improved by 3.3 percentage points between Q3 2023 and Q3 2024, and natural support utilization rose from 92.2% to 92.7%, a gain of 0.5 points. Routine review of quality-of-care cases, incident reports, and performance trends ensures that all entities—Wraparound Agencies, Family Support Organizations, and clinical providers—operate under uniform quality expectations and equitable monitoring standards. These mechanisms preserve fairness across the system and uphold CSoC's commitment to delivering consistent, high-quality care for all enrolled youth.

Through these priorities, CSoC enters the next phase of program maturity, focusing on the simultaneous sustainability of fidelity and equity. Each initiative is grounded in the principle that equitable outcomes are achieved when every youth and family, regardless of race, region, or socioeconomic status, receives the same high-quality, evidence-based support at the right time and intensity.

Appendices

Appendix A – Population Overview

Table A-1. CSoC Membership Demographic Characteristics, CY 2023 and CY 2024

Category	Subcategory	CY 2023 Number	CY 2023 Percent	CY 2024 Number	CY 2024 Percent
	Unique Enrollments	**3,785**	—	**4,283**	—
CSoC Region	Region 1	396	10.5%	505	11.8%
	Region 2	368	9.7%	532	12.4%
	Region 3	424	11.2%	452	10.6%
	Region 4	458	12.1%	499	11.7%
	Region 5	520	13.7%	549	12.8%
	Region 6	227	6.0%	242	5.7%
	Region 7	308	8.1%	382	8.9%
	Region 8	264	7.0%	288	6.7%
	Region 9	820	21.7%	834	19.5%
Geographic	Urban/Suburban	922	24.4%	1,174	26.8%
	Rural	2,835	74.9%	3,109	72.6%
	Unknown	27	0.7%	26	0.6%
Gender	Female	1,668	44.1%	1,854	43.3%
	Male	2,117	55.9%	2,429	56.7%
Race	Black/African American	1,958	51.7%	2,233	52.1%
	White	1,674	44.2%	1,787	41.7%
	Multi-Racial[1]	—	N/A	—	N/A
	Other/Single Race	36	1.0%	17	0.4%
	American Indian/Alaskan Native	33	0.9%	45	1.1%
	Native Hawaiian/Pac. Islander	8	0.2%	5	0.1%
	Asian	4	0.1%	4	0.1%
	Unknown	72	1.9%	192	4.5%
Ethnicity	Non-Hispanic/Non-Latino	3,667	96.9%	4,073	95.1%
	Hispanic/Latino	39	1.0%	17	0.4%
	Unknown	79	2.1%	193	4.5%
Primary Language	English	3,754	99.2%	4,253	99.3%
	Spanish	17	0.4%	13	0.3%
	Vietnamese	1	0.0%	1	0.0%
	American Sign Language (ASL)	11	0.3%	13	0.3%
	Not Declared	0	0.0%	0	0.0%
	Unspecified	2	0.1%	3	0.1%

Source: Louisiana Medicaid Eligibility File and TruCare Care Management System (CM), Magellan Health of Louisiana; data extracted January 2025.

[1] Multi-racial category was not captured separately.

Appendix B – Process Equity

Table B-1. Wraparound Fidelity Results by Indicator, CY 2023–CY 2024

Element	Question	CY 2023 Denom.	CY 2023 Percent	CY 2023 Denom.	CY 2024 Percent
Family Voice & Choice	Family preferences addressed	2,030	99.2%	4,304	99.5%
	Needs prioritized by family and stakeholders addressed?	2,033	99.9%	4,286	99.1%
	Individualized to Youth and family's culture, preferences, strengths, and needs	2,033	99.4%	4,304	99.5%
	Strategies unique to family's culture, skills, abilities	2,033	99.8%	4,253	98.3%
Strength-Driven	Strengths for all team members	2,033	99.5%	4,291	99.2%
	Action steps strengthen caregivers	2,033	97.8%	4,217	97.5%
	Action steps matched to known functional strengths	2,033	99.8%	4,251	98.3%
	Action steps indicate skill not will team culture	2,033	99.8%	4,252	98.3%
Needs-Based	Needs linked to CANS/IBHA & reflect underlying needs	2,033	99.8%	4,155	96.1%
	Risk behaviors addressed	2,033	96.8%	4,169	96.3%
	Safety concerns addressed	1,909	98.6%	4,326	100.0%
	Are services, amount, frequency, type, and duration supported by needs and strategies?	2,018	96.8%	4,181	97.4%
Outcomes-Based	Plan is data driven	2,033	99.9%	4,314	99.7%
	EBP considered when appropriate	1,840	97.0%	3,116	96.7%
	Refinement and changes to strategies to reflect strengths and needs and effectiveness	1,222	98.5%	2,439	98.5%
	Action to resolve barriers	1,555	91.1%	3,170	93.8%
Natural & Community Supports	Diverse team	2,033	97.5%	4,290	99.2%
	Informal/natural supports have strategies	2,033	87.3%	2,845	84.9%
	Community-based interventions (formal & informal) included in plan	2,033	99.3%	3,321	99.1%
	Available community-based crisis and/or respite services are utilized	2,013	97.4%	4,158	98.4%
Effective Teamwork	Team Mission	2,033	99.6%	4,319	99.8%
	Multiple team members (beyond Caregiver and Youth) have action steps	2,033	97.6%	4,215	97.4%
	Graduation plan is congruent with team mission	2,024	99.7%	3,282	99.6%
	Activities and Goals Providers are working on are included in the plan	1,207	98.9%	2,428	99.2%

Source: Louisiana TruCare Care Management System (CM), Magellan Health of Louisiana; data extracted January 2025.

Note: Denominators vary by indicator based on applicability and eligibility criteria.

Appendix C – Infrastructure for Equity Measurement

Table C-1. Performance on Indicator 1 and Indicator 2, CY 2023 Baseline and CY 2024 Remeasurement

		Indicator 1			Indicator 2		
Time Period	**Date Span**	**Denom.**	**Num.**	**Percent**	**Denom.**	**Num.**	**Percent**
Baseline	01/2023 – 12/2023	1,864	682	36.8%	1,242	580	46.9%
Remeasurement Yr. 1	01/2024 – 12/2024	3,221	1,391	43.2%	2,476	1,073	43.3%

Source: Louisiana TruCare Care Management System (CM), Magellan Health of Louisiana; data extracted January 2025.

Table C-2. Member Grievance Process Measures, CY 2023 and CY 2024

Process Outcome	CY 2023 Denom.	CY 2023 Percent	CY 2024 Denom.	CY 2024 Percent
Clinically Urgent	0	0%	0	0%
Acknowledged Timely	17	100%	12	100%
Resolved Timely	17	100%	12	100%
Notice of Resolution Sent in Timely	17	100%	12	100%

Source: Magellan Comments and Resolution Tracking System (CRTS); data extracted January 2025.

Appendix D – Outcome Equity

Table D-1. Comparison of Outpatient and Waiver Service Utilization, CY 2023 vs. CY 2024

Services Categories	CY 2023 Eligible (N)	CY 2023 Receiving Service (N)	CY 2023 % Served	CY 2024 Eligible (N)	CY 2024 Receiving Service (N)	CY 2024 % Served
All Outpatient Services	5,015	3,180	63.4%	5,203	3,515	67.6%
Traditional OP Therapy	5,015	1,672	33.3%	5,203	1,995	38.3%
Independent Living Skills Building (ILSB)	3,325	162	4.9%	2,965	164	5.5%
Parent Support and Training (PST)	5,015	1,850	36.9%	5,203	2,114	40.6%
Short-Term Respite (STR)	5,015	743	14.8%	5,203	943	18.1%
Youth Support and Training (YST)	4,026	970	24.1%	3,786	1,007	26.6%

Source: Data reported by Wraparound Agencies (WAAs) via the CSoC Data Spreadsheet and integrated into Magellan's CSoC data repository, combining TruCare Care Management and Opeeka data; data extracted January 2025.

Appendix E – Member Experience and Voice

Table E-1. Member Satisfaction Survey Results by Question, CY 2023 and CY 2024

Question	Year	Total Respondents (N)	Positive	Neutral	Negative
Overall, how satisfied are you with the services provided by CSoC (Magellan)?	2023	290	91.0%	5.2%	3.8%
	2024	301	89.7%	8.0%	2.3%
How pleasant or unpleasant was it to work with CSoC (Magellan)?	2023	294	91.8%	6.1%	2.0%
	2024	304	92.1%	6.3%	1.6%
How easy or difficult was it to get what your child needed?	2023	293	75.8%	15.7%	8.5%
	2024	305	75.4%	16.1%	8.5%
How effective or ineffective was CSoC (Magellan) at meeting your child's needs?	2023	293	85.0%	10.2%	4.8%
	2024	305	82.6%	14.1%	3.3%
The services my child receives through CSoC (Magellan) are available at times that are good for us.	2023	295	89.2%	7.1%	3.7%
	2024	307	87.0%	10.1%	2.9%
My child can get services as soon as they are needed.	2023	294	73.5%	12.2%	14.3%
	2024	308	76.3%	12.7%	11.0%
My child has access to quality behavioral healthcare.	2023	294	84.7%	8.8%	6.5%
	2024	303	84.8%	9.2%	5.9%
I am happy with the choice of behavioral healthcare providers my child has through CSoC (Magellan).	2023	293	86.7%	8.2%	5.1%
	2024	305	84.9%	9.2%	5.9%
CSoC (Magellan) behavioral support providers respect my family's cultural and language needs.	2023	291	93.5%	4.1%	2.4%
	2024	301	95.7%	4.3%	0.0%
My CSoC support providers help me get information to help me manage my health.	2023	291	89.0%	6.9%	3.1%
	2024	306	91.8%	6.9%	1.3%
Did you use language assistance services (interpretation, translation services)?	2023	296	1.7%	-	98.3%
	2024	309	2.9%	-	97.1%
The language assistance services received through CSoC were helpful (interpretation and translation services).	2023	1	100.0%	0.0%	0.0%
	2024	3	100.0%	0.0%	0.0%
The language assistance services (interpretation, translation services) make sessions with my provider better.	2023	5	100.0%	0.0%	0.0%
	2024	6	33.3%	66.7%	0.0%

Source: Qualtrics Member Experience Survey Platform; Magellan Health of Louisiana, CY 2024 survey administration.

Table E-2. Inpatient Psychiatric Utilization and Length of Stay, Q1 2023 – Q4 2024

Quarter	Total Enrolled Members (N)	Inpatient Psychiatric Hospital Admissions (N)	% of Members with Inpatient Stay	Average Length of Stay (Days)
Q1 2023	2,685	192	7.2%	5.9
Q2 2023	2,721	165	6.1%	7.4
Q3 2023	2,667	164	6.2%	8.3
Q4 2023	2,504	169	6.8%	6.1
Q1 2024	2,559	151	5.9%	6.0
Q2 2024	2,605	174	6.7%	6.2
Q3 2024	2,617	177	6.8%	6.4
Q4 2024	2,723	190	7.0%	6.5

Source: Louisiana TruCare Care Management System (CM), Magellan Health of Louisiana; data extracted January 2025.