LOUISIANA DEPARTMENT OF HEALTH

State Fiscal Year July 1, 2022–June 30, 2023

External Quality Review Technical Report

for

Magellan of Louisiana

April 2024

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,[1-1] with further revisions released in November 2020.[1-2] The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Louisiana Department of Health (LDH) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

The Louisiana Medicaid Managed Care Program

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

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral healthcare, including Humana Healthy Horizons, which started on January 1, 2023; and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Jan 2, 2024.

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

1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2023 (July 1, 2022–June 30, 2023) are displayed in Table 1-1.

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 (new plan as of 01/01/2023)	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA
Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS EQR Protocols released in February 2023.[1-3] For the SFY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 2, 2024.

the quality, timeliness, and accessibility of healthcare services provided by the PIHP. Table 1-2 depicts the EQR activities conducted for each plan type.

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

EQR Activities	Description	Protocol	MCO	PAHP	PIHP
Performance Improvement Project (PIP) Validation	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting and, whether the PIP demonstrated significant improvement in performance.	Protocol 1. Validation of Performance Improvement Projects	✓	✓	✓
Performance Evaluation and Improvement	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures	✓	✓	✓
Compliance Reviews (CRs)	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations	✓	✓	✓
Network Adequacy and Availability Validation (NAV)	This activity assesses the extent to which an MCE has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*	✓	✓	✓
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	✓	n/a	n/a
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	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		

EQR Activities	Description	Protocol	MCO	PAHP	PIHP
	services have on members receiving those services.				
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	✓		

**Protocol 4. Validation of Network Adequacy* was released in February 2023; therefore, full implementation will occur with the 2024 NAV activities.

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 2023. 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.	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." 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] 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 2023 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 weaknesses in each domain of quality, timeliness, and access to services furnished by the PIHP for the EQR activity.

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

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

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

Louisiana's Medicaid Managed Care Quality Strategy

In accordance with 42 CFR §438.340, LDH implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Louisiana Medicaid managed care members under the Louisiana Medicaid managed care program. Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated June 2022 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 Louisiana Medicaid managed care program is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid members.

Goals and Objectives

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

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

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

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

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

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

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

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

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

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

LDH considers the quality strategy to be its roadmap for the future. Overall, the quality strategy represents an effective tool for measuring and improving the quality of Louisiana's Medicaid managed care services. The quality strategy promotes identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Louisiana Medicaid managed care members. Additionally, LDH's initiatives tie to the quality strategy aims, goals, and objectives. The quality strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value- and quality-based, data-driven, and equitable.

LDH conducts oversight of the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. The MCE should be committed to QI and its overall approach, and specific strategies will be used to advance the quality strategy and incentive-based quality measures.

Recommendations

HSAG's EQR results and guidance on actions assist LDH in evaluating the MCEs' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist LDH and the MCEs in achieving and exceeding goals. In addition to providing each MCE with specific guidance, HSAG offers LDH the following recommendations, which should positively impact the quality, timeliness, and accessibility of services provided to Medicaid members:

- HSAG recommends LDH consider a change in metric benchmarks so the MCEs can strive toward a consistent performance level. HSAG recommends LDH remove the target objectives and improvement objectives and establish benchmarks for all MCEs that align with nationally recognized quality measures (e.g., NCQA Quality Compass, CMS Adult and Child Core Sets) or the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.

[1-4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Jan 2, 2024.

- HSAG recommends LDH consider using the measurement year (MY) 2023 reported rates in the 2024 quality strategy evaluation, which could include MY 2021 through MY 2023 results in order to include the most current data for evaluation.
- HSAG recommends LDH remove the duplicate objective, promote healthy development and wellness in children and adolescents.
- HSAG recommends LDH consider adding the objectives, improve overall health and promote reproductive health objectives, to the quality strategy.
- HSAG recommends LDH continue to collaborate with the MCOs to support adequate QI capacity, skills, and resources to support current and future PIPs. HSAG recommends LDH continue to meet regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could consider incorporating a similar mechanism for the PAHPs to collaborate on current and future PIPs. HSAG also recommends LDH consider hosting a forum in which the MCEs could discuss programwide solutions to overcome barriers. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.
- HSAG recommends LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.
- HSAG recommends the MCEs consider whether there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends the MCEs target QI interventions to reduce the identified disparities.
- HSAG recommends LDH consider working with the MCEs to share performance measure best practices and identify interdependencies across measures.
- HSAG recommends LDH consider a contract statement for all MCEs that the MCE's quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.

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 2023.

Validation of Performance Improvement Projects

For the SFY 2023 PIP validation, the PIHP submitted for validation the design of a new PIP focused on the quality of wraparound care plans and use of evidence-based practices in wraparound care plans for youth in the eligible population. The PIHP PIP submission demonstrated strengths in adhering to an acceptable methodology for the PIP design (Steps 1 through 6 of CMS' EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 [CMS Protocol 1]),[1-5] including Aim statement, population definition, performance indicator definitions, and data collection methodology. Magellan had not progressed to reporting performance indicator results or interventions for the PIP during the initial validation cycle in SFY 2023. The PIHP will progress to the implementation stage, reporting baseline indicator results and initial improvement strategies, for validation in SFY 2024. HSAG will include the baseline indicator results, initial interventions, and overall SFY 2024 validation findings in next year's EQR technical report.

Validation of Performance Measures

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

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

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

[1-5] 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: Jan 2, 2024.

Because the measures selected for validation change each year, no year-to-year comparisons could be made for most of these measures. *Follow-Up After Hospitalization for Mental Illness* was included in the validation scope for the prior year, so year-to-year comparisons are included below.

Assessment of Compliance With Medicaid Managed Care Regulations

In HSAG's CR, Magellan scored 100 percent for Standard IV—Emergency and Poststabilization Services, demonstrating strong performance in this area. Magellan received a performance score below 90 percent for Standard I—Enrollment and Disenrollment (50.0 percent), which identified that Magellan has opportunities for improvement.

HSAG also reviewed Magellan's corrective action plans (CAPs) from the LDH-approved 2022 CR. Magellan achieved compliance in 26 of 26 elements from the 2022 CAPs, demonstrating full remediation of CAPs from 2022.

Validation of Network Adequacy

Magellan's GeoAccess reports showed results of between 99 percent to 100 percent of members having access to four behavioral health provider types, within the required distance standards, in the urban centers. However, rural access did not meet GeoAccess standards for three of four behavioral health provider types.

2. Validation of Performance Improvement Projects

Results

SFY 2023 was the first year that HSAG was contracted as the EQRO for LDH and the first year that HSAG validated Magellan's PIP. Table 2-1 summarizes the SFY 2023 PIP performance for the PIHP. The PIHP conducted a PIP focusing on improving the use of evidence-based wraparound care planning for enrollees.

Validation Results and Confidence Ratings

Table 2-1—PIP Validation Results and Confidence Ratings

PIP Topic	Validation Rating 1: PIP Demonstrated Adherence to Acceptable Methodology	Validation Rating 2: PIP Demonstrated Significant Improvement
Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team	***High Confidence***	***Not Assessed***
	100% of All Evaluation Elements Met	
	100% of Critical Evaluation Elements Met	

For the SFY 2023 PIP validation, Magellan received *High Confidence* for Validation Rating 1. The PIHP received *Met* scores for 100 percent of applicable evaluation elements in steps 1 through 6 of the PIP validation tool, demonstrating strength in adhering to acceptable methodologies for selecting the PIP topic and developing the Aim statement, population definition, performance indicator definitions, sampling methods, and data collection process. For Validation Rating 2, which is based on scores in Step 9 of the PIP validation tool, Magellan's PIP was *Not Assessed* for this year's validation. The PIP will be assessed for Validation Rating 2 when Magellan progresses to reporting remeasurement results for the performance indicators and evaluating whether improvement over baseline was demonstrated. In SFY 2024, Magellan will progress to reporting baseline indicator results and initial improvement strategies, and HSAG will validate the PIP through Step 8. The SFY 2024 PIP validation findings, baseline indicator results, and initial improvement strategies will be included in next year's EQR technical report.

Interventions

For the SFY 2023 PIP validation, Magellan developed the PIP design, establishing the methodological foundation for the project, but had not yet progressed to identifying barriers to improvement or developing interventions. Magellan will report initial interventions in SFY 2024, and the interventions and HSAG's assessment as part of the SFY 2024 validation will be reported in next year's EQR technical report.

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- The PIHP developed a methodologically sound design for the PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- Magellan received *Met* scores for 100 percent of applicable evaluation elements for the SFY 2023 PIP validation; therefore, HSAG did not identify any opportunities for improvement or recommendations.

Methodology

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 CMS 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 CMS 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)**
   a. *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.
   b. *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.
   c. *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*.
   d. *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)**
   a. *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   b. *Moderate Confidence*: One of the three scenarios below occurred:
      i. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
      ii. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
      iii. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   c. *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.
   d. *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 weaknesses 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 CMS 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 each PIP topic to one or more of these three domains. While the focus of a 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 valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-2.

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

Performance Improvement Project	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 their CSoC members. For calendar year 2023, OBH required Magellan to report a total of 49 measures across different areas of focus, including care management, utilization management, grievance and appeals, and quality management. Of these measures, OBH selected five quality management performance measures to be validated by HSAG.

Information Systems Capabilities Assessment

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

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

Performance Measures

A review of data by HSAG determined that the rates reported by Magellan were calculated in accordance with the defined specifications and that there were no data collection or reporting issues identified. All five measures reviewed passed HSAG's validation and received a *Reportable* designation.

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

Table 3-1—Validated Measures

Performance Measure	Type of Measure	Measure Designation	Reporting Period
Follow-Up After Hospitalization for Mental Illness—7-Day	HEDIS with LDH modifications to the specifications	R	January 1, 2022–December 31, 2022
Follow-Up After Hospitalization for Mental Illness—30-Day			

Performance Measure	Type of Measure	Measure Designation	Reporting Period
CANS Outcomes	LDH	R	July 1, 2022–June 30, 2023
Living Situation at Discharge	LDH	R	July 1, 2022–June 30, 2023
Improved School Functioning	LDH	R	July 1, 2022–June 30, 2023
Utilization of Natural Supports	LDH	R	July 1, 2022–June 30, 2023

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

Follow-Up After Hospitalization for Mental Illness

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

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

Reporting Year	7-Day	30-Day
MY 2021	46.81%	66.67%
MY 2022	69.78%	82.50%

CANS Outcomes[3-1]

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

Table 3-3—CANS Outcomes Measure Results

Reporting Quarter	Percentage of youth who have been enrolled for at least 90 days who are discharging with valid change scores	Percentage of youth showing improved clinical functioning in CSoC
Quarter 1 (July 1, 2022–September 30, 2022)	90.67%	68.29%
Quarter 2 (October 1, 2022–December 31, 2022)	95.69%	65.59%
Quarter 3 (January 1, 2023–March 31, 2023)	95.93%	65.52%
Quarter 4 (April 1, 2023–June 30, 2023)	93.86%	71.34%

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

Results fluctuated from Quarter 1 to Quarter 4, with Quarter 4 demonstrating the highest percentage (71.34 percent) of youth showing improved clinical functioning.

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	Quarter 1 (July 1, 2022–September 30, 2022)	Quarter 2 (October 1, 2022–December 31, 2022)	Quarter 3 (January 1, 2023–March 31, 2023)	Quarter 4 (April 1, 2023–June 30, 2023)
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%
Percentage of youth discharging into a home and community-based (HCB) setting	93.95%	94.44%	93.86%	92.38%
Percentage of youth discharging to family home	91.32%	93.21%	90.28%	90.32%
Percentage of youth discharging to foster care	2.63%	1.23%	3.58%	2.05%
Percentage of youth discharging to inpatient hospital	0.00%	0.62%	1.28%	0.59%
Percentage of youth discharging to residential placement	4.21%	3.70%	2.30%	4.99%
Percentage of youth discharging to juvenile justice setting	1.32%	1.23%	2.05%	0.88%
Percentage of youth discharging to other setting	0.53%	0.00%	0.51%	1.17%

For each quarter during SFY 2023, the results indicate that over 90 percent of youth were discharged into an HCB setting or family home.

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	Quarter 1 (July 1, 2022–September 30, 2022)	Quarter 2 (October 1, 2022–December 31, 2022)	Quarter 3 (January 1, 2023–March 31, 2023)	Quarter 4 (April 1, 2023–June 30, 2023)
CANS compliance rate	91.05%	95.69%	92.62%	93.86%
Percentage of children showing improved school functioning in CSoC	59.57%	56.42%	62.90%	60.47%
Percentage of children with improved school attendance	52.45%	53.78%	53.64%	56.39%
Percentage of children with improved school behavior	59.21%	53.57%	58.89%	55.92%

For SFY 2023, the results indicate that approximately 60 percent of children showed improved school functioning, approximately 55 percent of children had improved school attendance, and approximately 57 percent of children improved their school behavior.

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)	Quarter 1 (July 1, 2022–September 30, 2022)	Quarter 2 (October 1, 2022–December 31, 2022)	Quarter 3 (January 1, 2023–March 31, 2023)	Quarter 4 (April 1, 2023–June 30, 2023)
All members	89.62%	87.71%	88.38%	88.69%
Members enrolled 0–90 days	80.40%	79.18%	82.64%	82.24%

Percentage of Enrollees With at Least One Natural/Informal Support on the Plan of Care (POC)	Quarter 1 (July 1, 2022–September 30, 2022)	Quarter 2 (October 1, 2022–December 31, 2022)	Quarter 3 (January 1, 2023–March 31, 2023)	Quarter 4 (April 1, 2023–June 30, 2023)
Members enrolled 91–180 days	89.65%	84.96%	82.35%	85.39%
Members enrolled 181–360 days	90.31%	90.25%	91.49%	90.96%
Members enrolled 361–540 days	92.53%	91.30%	92.95%	92.41%
Members enrolled 541+ days	92.08%	91.43%	91.61%	90.78%

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- Magellan identified that it had implemented various quality interventions to target increased performance and address the needs of youth enrolled in CSoC. Magellan developed and distributed value-based payments to wraparound agencies and supervisors for youth receiving outpatient licensed mental health professional (LMHP) and/or psychiatrist services and for youth attending follow-up services after any mental health hospitalization within seven days of discharge. In addition, value-based payments were distributed as retention payments for peer services and supervisors, wraparound facilitators, and to compensate for the number of wraparound agency facilitator vacancies. Lastly, Magellan developed and distributed add-on payments to LMHPs and psychiatrists who served CSoC youth. **[Quality, Timeliness, and Access]**
- Magellan's reported rates for *Follow-Up After Hospitalization for Mental Illness—7-Day and 30-Day* significantly increased from MY 2021 to MY 2022. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-2] **[Quality, Timeliness, and Access]**

For Magellan, the following opportunity for improvement was identified:

- After review of Magellan's member-level detail file, HSAG identified duplicate members (i.e., members listed multiple times with the same inpatient discharge date) for the *Follow-Up After Hospitalization for Mental Illness* measure. **[Quality]**

[3-2] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Jan 2, 2024.

For Magellan, the following recommendations were identified:

- Magellan indicated that it had identified 51 duplicate members, which were removed from the member universe. While Magellan was proactive in addressing the duplicate members, HSAG recommends that Magellan implement additional validation checks to further ensure accurate member-level data prior to submission to HSAG. This additional level of validation could involve reviewing the member-level data to ensure that there are no duplicates and that the discharge dates are appropriate. **[Quality]**
- To enhance processes for monitoring, tracking, and trending the quality, timeliness, and availability of care and services, Magellan and LDH should consider collaborating to establish quality metrics (i.e., performance standards) related to the performance measures. Having established performance standards provides an opportunity to further evaluate areas of strength, barriers, and opportunities for improvement, and supports overall performance improvement. **[Quality, Timeliness, 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

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

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

[3-3] 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: Jan 2, 2024.

- **Performance measure reports**—HSAG also reviewed the PIHP's SFY 2022 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 CMS Protocol 2, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **ISCAT—**HSAG received this tool from the PIHP. The completed ISCAT provided HSAG with background information on the PIHP's policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from the PIHP (if applicable). If the PIHP did not produce source code to generate the performance indicators, the PIHP submitted a description of the steps taken for measure calculation from the point that the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the measure specifications.
- **Previous Performance Measure Results Reports—**HSAG obtained these reports from LDH and reviewed the reports to assess trending patterns and rate reasonability.
- **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 weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, 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	X	X	X
CANS Outcomes	X		X
Living Situation at Discharge	X		n/a
Improved School Functioning	X		X
Utilization of Natural Supports	X		X

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

In CY 2022, the first year of a new three-year review cycle, LDH's former EQRO conducted a CR covering a review period of CY 2021 and most of the federally required standards. In CY 2023, HSAG conducted a CR for Standard I—Enrollment and Disenrollment and Standard IV—Emergency and Post-Stabilization Services (these standards had not been included in the prior year's CR), thereby completing the required evaluation for the administrative and compliance process in a three-year period. LDH plans to use CY 2024 for remediation and to prepare for a new CR cycle. Table 4-1 presents an overview of the results for Magellan.

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

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

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

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

During the 2023 CR, Magellan scored 100 percent for Standard IV—Emergency and Poststabilization Services, demonstrating strong performance in this area. Magellan received a performance score below 90 percent for Standard I—Enrollment and Disenrollment (50.0 percent), which identified that Magellan has opportunities for improvement. HSAG assigned a score of Met or Not Met to each of the individual

elements it reviewed. For any elements HSAG scored Not Met, Magellan is required to submit a CAP to bring the element into compliance with the applicable standard(s).

Follow-Up on Previous Compliance Review Findings

LDH contracted HSAG to assess the remediation Magellan conducted as a result of the deficiencies identified in the prior year's compliance review (conducted by LDH's previous EQRO). Magellan was issued a CAP and required to remediate each element as recommended by the previous EQRO. During this year's virtual partial compliance audit, HSAG reviewed the recommendations made by the previous EQRO and Magellan's response. Magellan submitted additional documentation or implemented policies and procedures to meet requirements. Magellan also completed a response document to describe its remediation efforts for each element. HSAG then assessed all remediation elements to determine if compliance with requirements had been met and assigned a final score. Table 4-2 presents an overview of the results for Magellan.

Table 4-2—Summary of Scores for the CAP From the CY 2021 Review

	Total Elements in CAP	Number of Elements		Total Compliance Score From CAP
		M	*NM*	
Follow-Up on CAPs From Prior Compliance Review	26	26	0	100%

M=*Met*, ***NM***=*Not Met*
Total Elements in CAP: The total number of elements within the CAP from the CY 2021 review. This represents the denominator.
Total Compliance Score From CAP: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

Of the 26 items Magellan was required to remediate from the prior compliance review, 26 were scored as *Met* by HSAG for a CAP remediation score of 100 percent.

For details, see Appendix B.

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- Magellan implemented documented processes that focus on ensuring members are not disenrolled for any reason other than discharge from the Coordinated System of Care. **[Access, Timeliness]**
- Magellan coordinates emergency services and inpatient discharges with the member's PIHP including coordinating follow-up behavioral health visits and, when needed, placement in a behavioral health inpatient or community setting. **[Quality]**
- Magellan has a documented policy that ensures Magellan works with providers to pay for the services and ensures that members who receive emergency services are not held liable for those

services and any subsequent screening and treatment needed to diagnose the condition or stabilize the patient. **[Quality]**

- Magellan did not place any limits on what constitutes an emergency service, and coordinates screening and treatment within 10 calendar days of presentation for emergency services. **[Access, Timeliness]**

For Magellan, the following opportunities for improvement were identified:

- Magellan's policies and procedures failed to include all requirements in Standard I—Enrollment and Disenrollment. **[Quality]**

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

- Magellan must revise its policies and procedures to include all requirements in Standard I—Enrollment and Disenrollment as detailed in the CR report. **[Quality]**

Methodology

Standards

Table 4-3 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In addition, HSAG conducted a follow-up review of the PIHP's implementation of CAPs from the CY 2021 CRs.

Table 4-3—Summary of CR Standards

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

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

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

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

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

Objectives

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

- The PIHP compliance with federal managed care regulations and contract requirements in the standard areas reviewed.

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

Technical Methods of Data Collection

To assess the PIHP's compliance with regulations, HSAG conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[4-1] Table 4-5 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 4-5—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and LDH contract requirements: • HSAG and LDH collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted CR tools, report templates, and agendas, and sent review dates to LDH for review and approval. • HSAG forwarded the CR tools and agendas to the PIHP. • HSAG scheduled the virtual reviews to facilitate preparation for the reviews.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted a PIHP pre-virtual review preparation session to describe HSAG's processes and allow the PIHP the opportunity to ask questions about the review process and PIHP expectations. • HSAG confirmed a primary PIHP contact person for the review and assigned HSAG reviewers to participate. • During the PIHP pre-virtual review preparation session, HSAG notified the PIHP of the request for desk review documents. HSAG delivered a desk review form, the CR tool, CAP implementation review tool, and a webinar review agenda via HSAG's Secure Access File Exchange (SAFE) site. The desk review request included instructions for

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

For this protocol activity,	HSAG completed the following activities:
	organizing and preparing the documents to be submitted. The PIHP provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and CR consisted of the completed desk review form, the CR tool with the PIHP's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct PIHP Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual review activities. • During the review, HSAG met with groups of the PIHP's key staff members to obtain a complete picture of the PIHP's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the PIHP's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the 2023 LDH-approved CR Report Template to compile the findings and incorporate information from the CR activities. • HSAG analyzed the findings and calculated final scores based on LDH-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to LDH**
	• HSAG populated and submitted the draft reports to LDH and the PIHPs for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the PIHPs and LDH.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and reports

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

How Data Were Aggregated and Analyzed

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

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

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to LDH and to each 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 weaknesses in each domain of quality, timeliness, and access to care furnished by each PIHP. HSAG then identified common themes and the salient patterns that emerged across PIHPs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the PIHP, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the PIHP. Table 4-6 depicts assignment of the standards to the domains of care.

Table 4-6—Assignment of CR Standards to the Quality, Timeliness, and Access Domains

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

Results

GeoAccess Provider Network Accessibility

Magellan's contract with LDH (effective dates August 1, 2022–July 31, 2025) requires Magellan to comply with the following GeoAccess standards:

- Travel distance to behavioral health specialists (psychologists, medical psychologists, advanced practice registered nurses or clinical nurse specialists, or licensed clinical social workers [LCSWs]) and psychiatrists for 100 percent of members:
  - Urban—15 miles
  - Rural—30 miles
- Travel distance to specialized behavioral health outpatient non-doctor of medicine (MD) services (e.g., outpatient specialty services):
  - Urban—60 miles
  - Rural—90 miles

Table 5-1 presents the percentage of members Magellan reported having access within the required distance standards for the reporting period of July 1, 2022–June 30, 2023.

Table 5-1—GeoAccess Results for Magellan

Specialty	Region	Standard	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Behavioral health specialists	Urban	15 miles/100%	99.6%	100%	99.8%	100%
	Rural	30 miles/100%	94.7%	95%	95.4%	96.0%
Specialized behavioral health non-MD outpatient services (e.g., specialty outpatient programs)	Urban	60 miles/100%	100%	100%	100%	100%
	Rural	90 miles/100%	100%	100%	100%	100%
Psychiatrists	Urban	15 miles/100%	99.2%	100%	99.8%	99.8%
	Rural	30 miles/100%	89.3%	89.3%	90.0%	80.3%
All prescribers	Urban	15 miles/100%	99.2%	100%	99.8%	99.8%
	Rural	30 miles/100%	90.3%	90.3%	91.2%	91.0%

Meets the required distance standards

Results of 99.0% or higher

Over the state fiscal year, Magellan provided access to behavioral health specialists, within the required distance standards, in the urban centers; however, rural access remained lower, gradually improving each quarter, from 94.7 percent in the first quarter of the fiscal year to 96 percent of members having access to behavioral health specialists within the required distance standards. Access to outpatient services remained consistent throughout the state fiscal year with 100 percent of members having access to behavioral health outpatient services within the required distance standards in both urban and rural regions. While access to psychiatrists fluctuated slightly, access in the urban centers remained above 99 percent each quarter, with more fluctuation and lower results in the rural regions. The rate for other prescribers remained relatively consistent from quarter to quarter in both urban and rural regions.

Magellan's gap analysis reports stated that there were no member grievances related to access in any of the four quarters of the state fiscal year. Magellan reported continued use of telehealth to fill gaps. In the Quarter 1 report, Magellan reported recruitment efforts aimed at 17 behavioral health specialists identified in Magellan's regions that were not contracted to provide services under CSoC. In Quarter 3, Magellan reported to be in negotiations with eight of these practitioners. In Quarter 4, Magellan reported assessing the root cause of the drop from 90 percent of members in Quarter 3 having access to a psychiatrist within the required distance standards to 80.3 percent in Quarter 4. Magellan attributed this drop to one provider with three locations who terminated from the network, moving to another state. Magellan reported that it planned to negotiate with that provider to continue to provide telehealth services to CSoC members. Additionally, Magellan reported that it is in the process of identifying other psychiatrists in rural areas to join the network and continues to evaluate the MCO networks for additional recruitment opportunities.

PIHP Strengths, Opportunities for Improvement, and Recommendations

For Magellan, the following strengths were identified:

- 100 percent of members had access to behavioral health outpatient services within the required distance standards in both urban and rural regions. **[Access]**
- Access to all behavioral health provider types was above 99 percent each quarter in urban areas. **[Access]**
- Magellan demonstrated gradual improvement for behavioral health specialists in rural areas. **[Access]**

For Magellan, the following opportunity for improvement was identified:

- Magellan did not meet GeoAccess standards in rural areas for behavioral health specialists, psychiatrists, and all prescribers. **[Access]**

For Magellan, the following recommendations were identified:

- Magellan should focus contracting efforts on rural areas for the three provider types that did not meet GeoAccess standards in order to contract with additional providers, if available, or implement additional strategies for expanding the provider network. **[Access]**
- Magellan should conduct an in-depth review of rural access, with the goal of determining whether failure to meet the standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Analyses should evaluate the extent to which the PIHP has requested exemptions from LDH for provider types for which providers may not be available or willing to contract. **[Access]**
- Magellan should consider offering additional telehealth services to increase compliance with GeoAccess standards. **[Access]**

Methodology

Objectives

The purpose of assessing the PIHP's reporting related to network adequacy is to evaluate the sufficiency of the provider network as reported by the PIHP, ensure the sufficiency of the network to provide adequate access to all services covered under the contract for all members, and provide recommendations to address network deficiencies.

Technical Methods of Data Collection

The PIHP was required to submit network analysis reports, GeoAccess mapping and tables, network gap analysis reports, and development plans depicting interventions or activities designed to address identified gaps in the networks. The PIHP used GeoAccess mapping software to calculate compliance with contractual distance standards for each required provider type. HSAG compared the PIHP's GeoAccess compliance reporting to the contractual standards.

Description of Data Obtained

The PIHP submitted GeoAccess mapping reports and tables, and gap analysis reports to LDH, which HSAG reviewed.

How Data Were Aggregated and Analyzed

HSAG used a standard reporting table to aggregate the GeoAccess mapping results for each provider type. HSAG determined whether the results for each provider type were compliant or noncompliant with

the contract standards. HSAG then reviewed the PIHP's reports to determine whether the PIHP developed interventions to address network deficiencies.

How Conclusions Were Drawn

HSAG determined that GeoAccess mapping not only provides insight into whether the access to specific providers is sufficient, but also, if network gaps exist, the quality of care a member receives may be impacted if care is received by nonqualified providers or not received at all.

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

NAV Activity	Quality	Timeliness	Access
GeoAccess Provider Network Accessibility Assessment	✓		✓

6. PIHP Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2023 to comprehensively assess Magellan's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides Magellan's strengths, opportunities for improvement, and recommendations in Table 6-1 through Table 6-3.

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

Overall PIHP Strengths	
Quality, Access, and Timeliness	• Magellan identified that it had implemented various quality interventions to target increased performance and address the needs of youth enrolled in CSoC. • Magellan's reported rates for *Follow-Up After Hospitalization for Mental Illness—7-Day* and *30-Day* significantly increased from MY 2021 to MY 2022.
Quality	• Magellan developed a methodologically sound design for the PIPs that facilitated valid and reliable measurement of objective indicator performance over time. • Magellan successfully remediated 26 of 26 findings from the previous compliance review CAP.
Access	• 100 percent of members had access to behavioral health outpatient services within the required distance standards in both urban and rural regions. • Access to all behavioral health provider types was above 99 percent each quarter in urban areas.

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

Overall PIHP Opportunities for Improvement	
Quality	• Magellan's member-level detail file contained duplicate members.
Access	• Magellan did not meet GeoAccess standards in rural areas for behavioral health specialists, psychiatrists, and all prescribers.

Table 6-3—Recommendations

Overall PIHP Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
Continue to implement quality interventions that demonstrate measurable gains in improving care coordination, follow-up, and member outcomes.	Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care
Collaborate with LDH to establish quality metrics (i.e., performance standards) related to the performance measures.	Goal 7: Pay for value and incentivize innovation
Implement additional validation checks to further ensure accurate member-level data prior to submission to HSAG.	Not applicable
To improve access to care, Magellan should: • Focus contracting efforts on rural areas for the three provider types that did not meet GeoAccess standards. • Conduct an in-depth review of rural access to behavioral health providers. • Offer additional telehealth services as appropriate.	Goal 1: Ensure access to care to meet enrollee needs

7. Follow-Up on Prior Year's Recommendations

Table 7-1 through Table 7-4 contain a summary of the follow-up actions that Magellan completed in response to the previous EQRO's SFY 2022 recommendations. Furthermore, HSAG assessed Magellan's approach to addressing the recommendations. Please note that the responses in this section were provided by the PIHP and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

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

High indicates *all* of the following:

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

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

Medium indicates one or more of the following:

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

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

Low indicates one or more the following:

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

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

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

Recommendations
It is recommended that LDH's decision regarding Magellan's request to continue the PIP be based on the extent that the Next Steps address these comments and demonstrate a robust approach to interventions based on lessons learned. In addition, goals should be set higher as recommended in the review comments.
Response
Describe initiatives implemented based on recommendations: The "Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects" were associated with a Performance Improvement Project (PIP) that Magellan discontinued in 2022. In the second quarter of 2023, Magellan embarked on a new PIP entitled "Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team."
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Magellan submitted the initial report for this new PIP to the Health Services Advisory Group (HSAG) in June 2023 for formal validation. In compliance with the Centers for Medicare & Medicaid Services (CMS) validation protocols, HSAG conducted a comprehensive evaluation of the PIP. This evaluation confirmed that Magellan's methodology met the established standards in all aspects of design and data collection. As a result of this evaluation, HSAG awarded a "High confidence" rating, signifying that Magellan had successfully fulfilled all the critical evaluation criteria. This rating confirms the integrity of the methods employed in the new PIP and emphasizes their effectiveness.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Magellan is scheduled to provide quarterly and annual reports to the Louisiana Department of Health. The initial report covers the baseline measurement period from January 1, 2023, to December 31, 2023, and is expected to be submitted by January 30, 2024. This schedule of regular reports is designed to ensure continuous monitoring and facilitate the ongoing enhancement of the PIP, informed by the latest data and insights.
HSAG Assessment


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

Recommendations
None identified.

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

Recommendations
As described in Section 4, LDH contracted HSAG to validate Magellan's remediation of the deficiencies identified in the prior year's compliance review CAP. HSAG reviewed Magellan's responses and the additional documentation they submitted to assess whether compliance had been reached. The details of this follow-up are included in Appendix B.

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

Recommendations
None identified.

Appendix A. PIHP Response to the Health Disparities Focus Study

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

For the annual EQR technical report, HSAG requested information from Magellan regarding its activities related to identifying and/or addressing gaps in health outcomes and/or healthcare among its Medicaid population according to at-risk characteristics such as race, ethnicity, gender, and geography. Magellan was asked to respond to the following questions for the period of July 1, 2022, through June 30, 2023:

> *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)?*

Magellan Healthcare in Louisiana (Magellan) is the delegated Coordinated System of Care (CSoC) Contractor for the Louisiana Department of Health (LDH). The CSoC Unit conducts an annual evaluation of its Quality Improvement Program to evaluate effectiveness and outcomes, assess goal achievement, evaluate the deployment of resources, document and trend input from advisory groups, including youth, family members, and other stakeholders, and identify opportunities for improvement in the ongoing provision of safe, high-quality care and service to members. The below represents studies, initiatives, or interventions to identify and/or reduce differences in health outcomes, health status, or quality of care between members in Medicaid subgroups (e.g., race, ethnicity, gender, age, socio-economic status, geography, education) that were reported via the annual Quality Assurance / Process Improvement (QAPI) evaluation submitted to the Louisiana Department of Health for 01/01/2022 through 12/31/2022.

CSoC Population Assessment

Magellan is committed to providing effective, equitable, understandable, and respectful care and services responsive to the diverse demographics of CSoC membership. To facilitate successful collaboration and achievement of goals, Magellan recognizes that CSoC team members, including Wraparound Facilitators (WAFs) and formal providers, must have an inherent understanding of and respect for the diversity of expression, opinion, and preference among the youth and families served. Through this respect, the principle of family voice and choice is achieved in the Wraparound process. Magellan demonstrates our high regard for this principle by embracing families where they are and promoting strong connections with natural supports in their communities. Cultivating a sustainable connection to community supports allows for continued positive outcomes after discharging from CSoC.

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

Cultural competence is providing care that meets an individual's unique cultural needs. To successfully provide culturally competent care, our membership must be continually analyzed to identify youth and families' cultural, linguistic, and social needs. Like the Wraparound model, Magellan demonstrates respect and builds on the values, preferences, beliefs, culture, and identity of the youth and families served, focusing on the individual and community culture unique to each member.

Magellan collects member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that providers may respond appropriately to the cultural needs of CSoC youth and families. Demographic data is collected in many ways, including Magellan's member record, eligibility data feeds, and through routine assessments [i.e., the Independent Behavioral Health Assessment (IBHA) and the Child and Adolescent Needs and Strengths (CANS) assessment]. Member demographic data is collected voluntarily and is not required to be disclosed.

Magellan conducts an annual assessment of CSoC members and providers to assess characteristics of their cultural, ethnic, racial, and linguistic needs. When opportunities for improvement are identified, Magellan adjusts the availability of practitioners within its network to meet the needs and preferences of the CSoC membership. This report provides a comprehensive assessment of those characteristics, a review of social determinants of health, and an analysis of potential mental health disparities. The report also includes strategies to support culturally competent service delivery and identify member needs that must be addressed through complex case management and quality initiatives in 2023.

This report will provide information on some of the key demographic and relevant characteristics of the CSoC population. Areas addressed include:

- Members Served
- Geographic Classification and CSoC Region
- Gender, Race, and Ethnicity
- Children and Adolescents
- Diagnostic Prevalence (including SED)
- Intellectual/Development Disabilities
- Disparities in Health Outcomes
- Social Determinants of Health

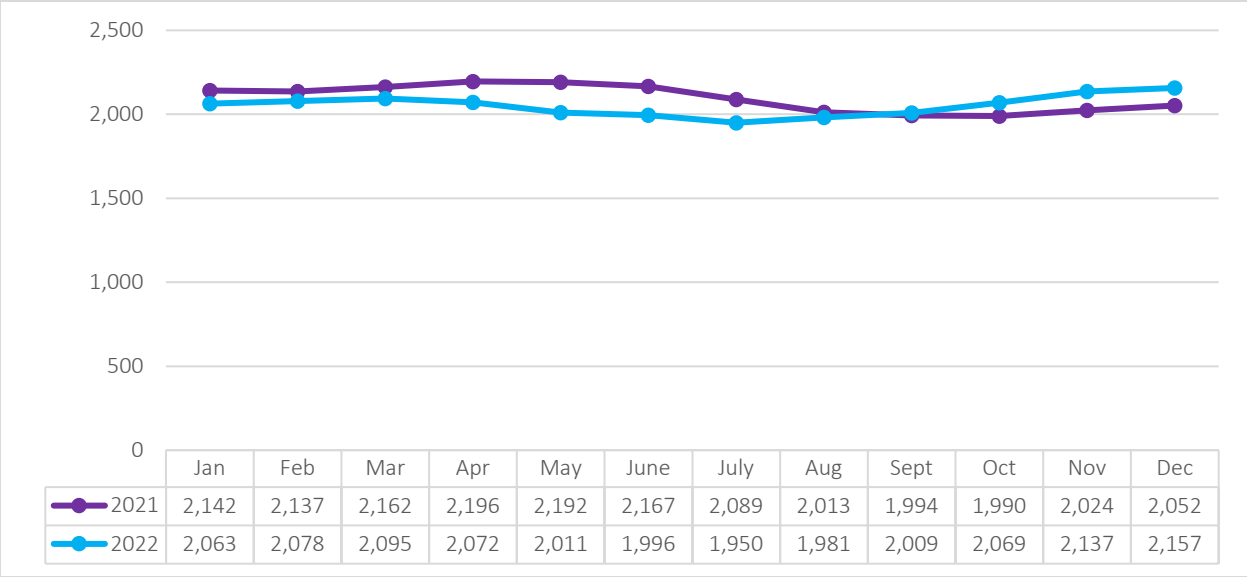
Member Demographics

Members Served

The primary data source for member demographics combines Medicaid eligibility and authorization data housed in Magellan's internal care and utilization management system. CSoC is a CMS waiver-funded program for Medicaid youth in Louisiana between the ages of 5 and 20. It expands access to intensive community-based behavioral healthcare to Medicaid youth who traditionally experience barriers to accessing healthcare. Anyone with the consent of the youth and family can initiate referrals to the program. CSoC can be accessed by 2,900

youth at any given time. The CSoC program served 3,639 unique members from 01/01/2021 through 12/31/2021 and 3,913 unique members from 01/01/2022 through 12/31/2022. Figure 1 provides enrollment-based authorizations on the last day of each month.

Figure 1. Enrollment on the Last Day of the Month of 2022

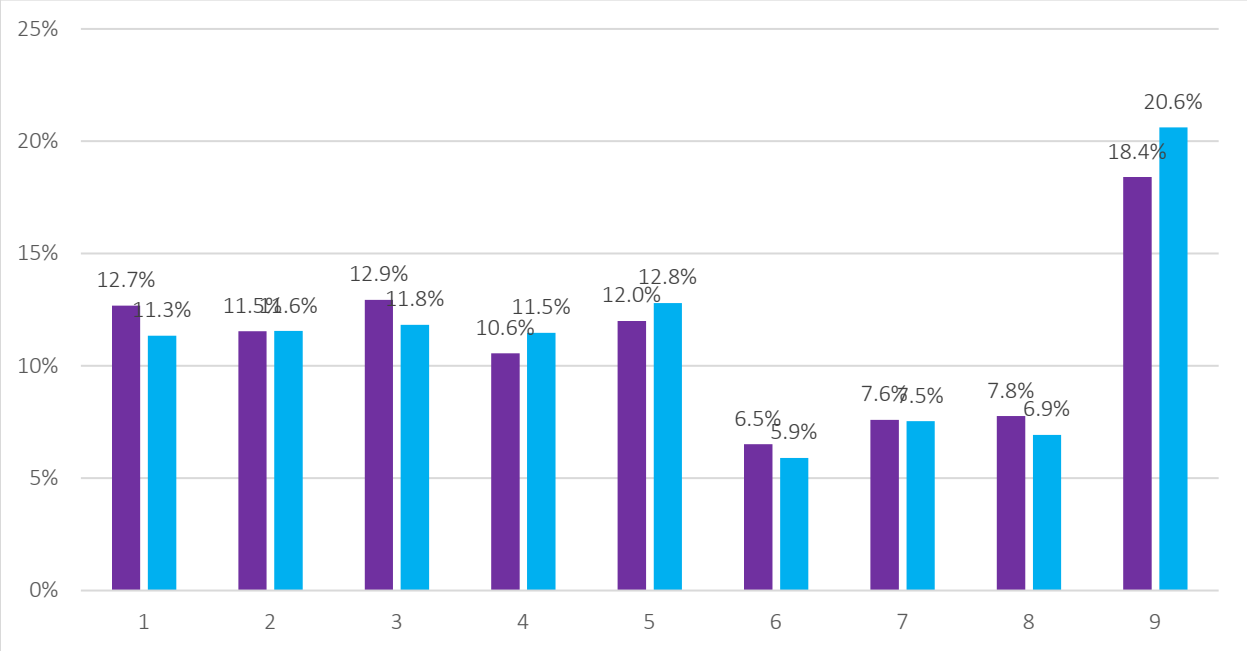


	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2021	2,142	2,137	2,162	2,196	2,192	2,167	2,089	2,013	1,994	1,990	2,024	2,052
2022	2,063	2,078	2,095	2,072	2,011	1,996	1,950	1,981	2,009	2,069	2,137	2,157

CSoC Regions

CSoC is divided into nine geographical regions to allow individual agencies to practice Wraparound specific to the needs of their communities. Although most regions serve members living in urban and rural areas, three regions have a more significant percentage of members residing in urban communities. These are Region 1 (New Orleans), Region 2 (Baton Rouge), and Region 8 (Shreveport). Magellan continually evaluates regional enrollment trends to ensure members from all regions can access CSoC. Region 9 had the highest census for the past two years, accounting for 18.4% of the total CSoC population in 2021 and 20.6% in 2022 (N = 3,913). Region 6 represented the lowest enrollment, accounting for 5.9% of the total population in 2022. Many factors, including urban/rural classification and referral source, can impact regional enrollment totals.

Figure 2. Average Annual Enrollment by Region



Geographic Classification

The geographic location of CSoC youth and families plays a crucial role in culture and access to care. Additionally, the location of residence can contribute to youths' exposure to crime, weather events, transportation, and resources. Most adolescents in the United States live in or just outside an urban area. Although adolescents in urban areas may be exposed to higher levels of violent crime, they are more likely to have access to playgrounds, community or recreation centers, parks, and other resources than their rural peers. Pediatricians and family physicians are key providers of basic behavioral health services. Healthcare providers in rural areas are less likely than their urban counterparts to provide behavioral health services to children and adolescents.

Table 1 below shows that most CSoC members or 73.7% reside in rural settings (N = 3,913). The remaining 25.63% resided in urban settings. These rates are like those in 2021, indicating the geographic makeup of CSoC members remains consistent.

Table 1. Geographic Classification on the Last Day of the Year

	2021		2022	
Member Group	Number	Percent	Number	Percent
Urban/Suburban	948	27.2%	1,003	25.6%
Rural	2,604	71.6%	2,883	73.7%
Unknown	46	1.3%	27	0.7%
Total	3,639	100%	3,913	100%

Rural adolescents are more likely to live in low-income households than adolescents in urban areas, and poverty is a reality for many Louisiana residents. While it is almost three years since the start of the Covid-19 pandemic,

families continue to struggle to recover financially. The US Census Bureau reports that, in 2022, 19.6% of Louisiana residents lived in poverty, a rate second only to Mississippi. Also, according to an analysis of Bureau of Labor (BLS) data, Louisiana is o states experiencing the highest inflation rates, at over 7%, increasing costs of utilities, food, and housing2. Growing up in poverty can create significant challenges for youth and families in urban and rural communities. The CSoC program provides every youth and family with a WAF to assist in developing a comprehensive Plan of Care (POC) that includes strategies and services to address functional and clinical needs. In addition to care planning, CSoC provides access to specialized waiver support services only available through the CSoC Program. Specialized waiver service providers meet CSoC youth and families in their homes and communities and provide additional support, such as mentoring, coaching, and skill development. These additional support services assist youth and families in accessing available healthcare services and community resources regardless of geographic classification or financial means.

Gender, Race, and Ethnicity

Many behavioral health studies have found disparities in access, use, and quality of behavioral health services among diverse ethnic and racial groups in the United States. Because this is a variable that can impact behavioral health outcomes, Magellan consistently monitors the race, gender, and ethnicity of our membership. In 2022, 43.27% of CSoC members were female, and 56.73% were male (N =3,913). This gender ratio was similar to that in 2021. African American youth comprise the highest percentage of CSoC members, representing 50.22% of the total population. The second highest percentage of members identify as White, at 43.29%. This aligns with research citing racial disparities for youth and children at the highest risk for out-of-home placement and/or arrest. Non-Hispanic/Latinos represent 96.89% of our membership (N = 3,913). The demographic makeup of CSoC membership has remained stable since the program's inception. There were no notable changes to the composition of age, race, gender, or ethnicity categories observed in 2021 or 2022.

Table 2. Gender of CSoC Members

	2021		2022	
Gender	Number	Percent	Number	Percent
Female	1,511	41.3%	1,693	43.3%
Male	2,218	58.5%	2,220	56.7%
Total	3,639	100%	3,913	100%

Table 3. Race of CSoC Members

	2021		2022	
Race	Number	Percent	Number	Percent
Black/African American	1,930	53.0%	1,965	50.2%
White	1,501	41.3%	1,694	43.3%
Multi-Racial	109	3.0%	142	3.6%
Other/Single Race	49	1.4%	60	1.5%
American Indian/Alaskan Native	25	0.7%	29	0.7%
Native Hawaiian/Pac. Islander	10	0.3%	9	0.2%

[2] Kaushal, T. Yahoo Finance: Inflation is Still Hitting Certain States Particularly Hard. February 22, 2023. https://finance.yahoo.com/news/inflation-impact-states-map-135604875.html

	2021		2022	
Race	Number	Percent	Number	Percent
Asian	3	0.1%	4	0.1%
Unknown	12	0.3%	10	0.3%
Total	3,639		3,913	

Table 4. Ethnicity of CSoC Members

	2021		2022	
Ethnicity	Number	Percent	Number	Percent
Non-Hispanic/Non-Latino	3,543	97.4%	3,795	96.9%
Hispanic/Latino	77	2.1%	92	2.4%
Unknown	19	0.5%	26	0.7%
Total	3,639		3,913	

CSoC Youth with Specialized Needs

Even among CSoC members, Magellan recognizes the existence of subpopulations that have unique characteristics and needs. Magellan has developed monitoring strategies and interventions that acknowledge these groups and remain flexible to address the emerging needs of youth and families.

Children and Adolescent Members

Medicaid criteria for enrollment in CSoC limit eligibility to youth between the ages of 5 and 20 years, which means that the entire population is categorized as a child or adolescent. Because of this, Magellan's medical team is led by a Medical Director that is double board-certified in General Psychiatry and Child and Adolescent Psychiatry. Her knowledge and experience ensure the specialized clinical needs of this population are addressed throughout all areas of operation.

CSoC enrollees have access to all Medicaid EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) benefits or wellness and preventative healthcare services to support the unique needs of this population group. In 2022, some key age characteristics of our members included:

- The total membership increased by 274 youth in 2022.
- The largest age group of members in 2021 and 2022 was 14-year-old members.
- Youth between the ages of 9 and 17 represented 78.8% of the membership (N = 3,913).
- Children 6 or younger represented approximately 4.9% of CSoC members.
- Youths 18 and over represent 6.9% of CSoC members.
- The distribution of ages remained consistent with the previous year.
- Due to the continued COVID eligibility provisions, the CSoC population included 14 members aged 21 or older in 2022 who were unable or unwilling to disenroll voluntarily.

Table 5. Age of CSoC Members

	2021		2022	
Age	Number	Number	Number	Percent
5	38	1.0%	65	1.7%
6	91	2.5%	125	3.2%
7	164	4.5%	172	4.4%
8	176	4.8%	196	5.0%
9	218	6.0%	234	6.0%
10	217	6.0%	249	6.4%
11	273	7.5%	307	7.8%
12	306	8.4%	328	8.4%
13	368	10.1%	366	9.4%
14	430	11.8%	446	11.4%
15	409	11.2%	442	11.3%
16	382	10.5%	410	10.5%
17	287	7.9%	302	7.7%
18	163	4.5%	153	3.9%
19	74	2.0%	67	1.7%
20	31	0.9%	37	0.9%
21	11	0.3%	13	0.3%
22	1	0.0%	1	0.0%
Total	3,639		3,913	

Youth transitioning into adulthood is a subset of the CSoC population with a unique need to develop and improve skills necessary to function successfully as adults in society (i.e., employment, housing, education, budgeting, etc.). In 2022, 47.8% of Magellan members were 14 or older (N = 3,913). Additionally, 22.6% of all youth had an actionable need for independent living at the initial assessment. One of the benefits of CSoC for these transition-aged youth is access to a specialized waiver service known as Independent Living/Skill Building (ILSB). This service is delivered in the community setting to train and prepare youth for adulthood. Some examples of skills that are developed through this service include:

- Life safety skills
- Ability to access emergency services
- Basic safety practices and evacuation
- Creating and implementing a personal budget
- Completing necessary domestic tasks, including laundry, grocery shopping, and essential food preparation
- Physical and mental health care maintenance, such as scheduling physician appointments
- Recognizing when to contact a physician and how to communicate needs effectively
- Self-administration of medication for physical and mental health conditions
- Understanding the purpose and potential side effects of medication prescribed for a condition

- Use of transportation (accessing public transportation, enrolling in driver training courses, obtaining auto insurance)

Serious Emotional Disturbance (SED)

A diagnosis defines a cluster of symptoms, experiences, or problems. Diagnosis may assist in treatment planning, connecting to others experiencing the same issues, and reducing the anxiety of the unknown. Specific diagnoses help people identify empirically supported treatments. In research spanning from 2016-2019, the Centers for Disease Control and Prevention (CDC) reported that the most diagnosed mental disorders in children are ADHD, anxiety, and depression[3]:

- 9.8% of US children aged 2-17 (approximately 6 million) have received an ADHD diagnosis.
- 9.4% of US children aged 3-17 (approximately 5.8 million) have been diagnosed with anxiety.
- 4.4% of children aged 3-17 (about 2.7 million) have been diagnosed with depression.

CSoC's clinical eligibility criteria require CSoC youth to have a SED diagnosis that places them at risk for or residing in an out-of-home placement. Given the high acuity of CSoC members' conditions, Magellan must monitor the diagnostic prevalence of our membership to meet their needs effectively. Magellan also recognizes our responsibility to make tools and supports readily accessible for CSoC practitioners and providers, which is achieved by adopting, developing, and distributing clinical practice guidelines. Clinical practice guidelines are based on sound scientific evidence for best practices. Magellan requires that our providers become familiar with these guidelines, including the following diagnoses and conditions:

- Acute Stress Disorder
- Post-Traumatic Stress Disorder
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Depression
- Generalized Anxiety Disorder
- Managing Suicidal Patients
- Obsessive-Compulsive Disorder
- Panic Disorder
- Schizophrenia
- Substance Use Disorders

Members enrolled in CSoC also receive a comprehensive assessment conducted by a licensed practitioner at referral and at least every 180 days after that. These assessments include clinical diagnoses to guide the services and strategies identified in youths' Plans of Care. In 2022, Magellan fully implemented a clinical quality improvement project designed to improve the quality of youth assessments and fully integrate assessors' clinical knowledge and experience into every step of treatment planning. When evaluating members' needs and determining necessary interventions, reducing health disparities, internal and external training needs, long-range fiscal planning and sustainability remains at the forefront. To that end, Magellan also provides screening tools to ensure that assessors are adequately equipped to assess the areas of need most observed in children and adolescents. These needs include co-occurring substance use disorders, depression, trauma, and conduct.

[3] Retrieved on 02/20/2021: https://www.cdc.gov/childrensmentalhealth/data.html

As shown in Table 6, the most prevalent diagnosis within the CSoC population in 2022 was ADHD, with 37.39% of members having some form of ADHD as their primary diagnosis (N = 3,913). Another prevalent diagnosis in 2022 was Adjustment Disorder, representing 26.34% of all primary diagnoses when all subtypes are combined. Major Depressive disorder and its subtypes accounted for 6.50% of 2022 primary diagnoses, and 6.11% of CSoC youth were reported to have a primary diagnosis of Autistic Disorder. In 2022, the Assessment Review Tool (ART) item *Principle Diagnosis* was added to the abbreviated ART. Its guidance expanded to note the importance of proper diagnosis in linking youth with Evidence-Based Practices (EBPs). This item will continue to be monitored throughout 2023 as efforts to empower assessors to utilize their clinical experience and knowledge to guide care continue. Magellan's Medical Director is crucial in supporting assessors through trainings on clinical best practices, including during All-Assessor calls. These calls facilitate discussion wherein assessors can ask for clarification, brainstorm novel approaches, and interact directly with Quality, Clinical, and Medical directors.

Magellan also monitors adherence to clinical practice guidelines for Suicide Risk, ADHD, Trauma-informed Care, and Conduct Disorders through the treatment record review process described in this report's Treatment Record Reviews section.

Table 6. Primary Diagnosis for CSoC Members

	2021		2022	
Diagnosis	Number	Percent	Number	Percent
F90.2: Attention-deficit hyperactivity disorder, combined type	616	16.9%	586	15.0%
F90.9: Attention-deficit hyperactivity disorder, unspecified type	602	16.5%	661	16.9%
F43.20: Adjustment disorder, unspecified	263	7.2%	293	7.5%
F91.3: Oppositional defiant disorder	214	5.9%	197	5.0%
F84.0: Autistic disorder	187	5.1%	239	6.1%
F90.1: Attention-deficit hyperactivity disorder, predominantly hyperactive type	170	4.7%	133	3.4%
F99: Mental disorder, not otherwise specified	119	3.3%	214	5.5%
F32.9: Major depressive disorder, single episode, unspecified	96	2.6%	97	2.5%
F43.25: Adjustment disorder with mixed disturbance of emotions and conduct	99	2.7%	586	15.0%
F90.0: Attention-deficit hyperactivity disorder, predominantly inattentive type	94	2.6%	83	2.1%
F43.10: Post-traumatic stress disorder, unspecified	78	2.1%	110	2.8%
F31.9: Bipolar disorder, unspecified	78	2.1%	59	1.5%
F34.81: Disruptive mood dysregulation disorder	n/a*	n/a*	74	1.9%
F39: Unspecified mood [affective] disorder	66	1.8%	n/a*	n/a*
F33.1: Major depressive disorder, recurrent, moderate	74	2.0%	79	2.0%
F33.0: Major depressive disorder, recurrent, mild	74	2.0%	78	2.0%
F43.24: Adjustment disorder with disturbance of conduct	66	1.8%	74	1.9%
F43.23: Adjustment Disorder with mixed anxiety and depressed mood	n/a*	n/a*	78	2.0%
F33.9: Major depressive disorder, recurrent, unspecified	59	1.6%	n/a*	n/a*
R69: Illness, unspecified	61	1.7%	79	2.0%

	2021		2022	
Diagnosis	Number	Percent	Number	Percent
Other	632	17.1%	687	17.6%
Total	3,639		3,913	

* Diagnosis did not make the top eighteen in that year.

CSoC Youth at Risk for Suicide

Numerous studies have shown that states administering intensive care coordination using the Wraparound model improved overall outcomes for enrolled youth and their caregivers, decreased out-of-home placements in residential/detention settings, and reduced the state's cost of providing services.[1] However, Bruns et al. (2015) noted that smaller effect sizes were observed in the clinical and functional outcomes compared to out-of-home placement and costs. He concluded that Wraparound could not achieve the full range of desired outcomes without attending to the quality of clinical interventions provided to youth and caregivers.[2] The inclusion of clinical interventions in care planning has become increasingly critical in recent years. In March 2023, Lebrun-Harris et al. published an article examining annual data from the National Survey of Children's Health (2016-2020), a study comprised of 174,551 American children. The results indicated increases in anxiety (7.1% [95% CI, 6.6-7.6] to 9.2% [95% CI, 8.6-9.8]; +29%; trend P < .001) and depression (3.1% [95% CI, 2.9-3.5] to 4.0% [95% CI, 3.6-4.5]; +27%; trend P < .001) since 2016 to 2022.[3]

These trends have also been observed in CSoC youth. In 2021 (N = 1,614) and 2022 (N = 1,792), 35.9% and 38.6% were identified as having actionable needs related to depression, while 28.2% and 31.3% had actionable needs related to anxiety. Additionally, clinical understanding has been increased, as evidenced by the number of CSoC youth that required medical attention in response to a suicide attempt. This rate increased from 0.3 in 2020 (N = 3,529) and 0.6 in 2021 (N = 3,639) to 1.3 in 2022 (N = 3,913). Further, a youth died of suicide in 2021, the first known suicide since the program's inception in 2012.[4]

In response to the increased clinical needs of CSoC youth, the Quality Improvement Committee (QIC) identified an opportunity to improve the ability of POCs to address trauma concerns and connect youth with EBPs when appropriate. Quantitative data was collected through provider record reviews. Additionally, qualitative data was gathered through interviews with WAA leadership and facilitators during monthly videoconference meetings, weekly inpatient staffings, and high-complexity staffings. Common barriers include:

- Lack of supervision/coaching of staff
- Lack of appropriate internal rules/policies/procedures

[1] Bruns, EJ.; Sather, A.; Pullmann, MD.; Brinson, RD.; Ramey, M. Effectiveness of wraparound vs. case management: Results of a randomized study in a "real-world" system; Poster presented at the Convention of the American Psychological Association, Division 37 (Child, youth, and family services); San Diego, CA. 2010.
[2] Bruns EJ, Walker JS, Bernstein, A, Daleiden E, Sather A, Pullmann MD, Chorpita BF. Family Voice with Informed Choice: Coordinating Wraparound with Research-Based Treatment for Children and Adolescents. Journal of Clinical Child Adolescent Psychology. 2014 ; 43(2): 256–269. Published online March 1, 2021. doi:10.1080/15374416.2013.859081.
[3] Lebrun-Harris, L, Ghandour, R., Kogan, M, Warren, M. Five-Year Trends in Children's Health and Well-being, 2016-2020. JAMA Pediatric . 2022;176(7):e220056. doi:10.1001/jamapediatrics.2022.0056. Published online March 14, 2022. Last corrected on January 9, 2023.
[4] Magellan of Louisiana's CSoC Quality Assurance / Process Improvement (QA/PI) Program Evaluation. 2022. Submission to LDH expected on February 28, 2023.

- Inefficient or complex workflow
- Staff knowledge or competency deficit
- Lack of supervision/coaching of staff
- Communication breakdowns between and among UM/CM, QI, and internal medical staff & WAA Clinical Directors, Supervisors/Coaches, and WAFs.
- Inability to share information among UM/CM, QI, and internal medical staff & WAA Clinical Directors, Supervisors/Coaches, and WAFs.
- Lack of availability of information to staff
- Misinterpretation of information by staff
- Decreases in leadership's commitment to improvement
- Facilitator fatigue, inattention, distraction, or heavy workload

Interventions

To address the barriers above, Magellan elicited participation from the WAAs to develop a consensus-based clinical procedure to outline specific actions that should be completed to ensure needs are adequately addressed. The Risk and Safety and Trauma procedures are described below. The procedures are informed by Wraparound principles and are intended to guide non-clinician Wraparound Facilitators in navigating the complex systems that support identifying youth that would benefit from referral and engagement with an LMHP and/or EBPs.

- Risk and Safety Procedure state there should be immediate communication to notify and consult an LMHP regarding the level of intervention needed for any youth with active suicidal or homicidal ideations with a plan. Upon consultation with an LMHP, a *Safety and Risk Summary* and an updated Plan of Care is completed and submitted. For youth with a history of suicide attempts, suicidal ideations, homicidal ideations, recent violent episodes, self-injury, or unsafe behaviors, the procedures give direction to assess emergent safety concerns and the presence or absence of current suicidal or homicidal ideation. Youth should be referred to an LMHP for assessment and treatment of comorbid mental health disorders, including the implementation of indicated therapeutic intervention, and referred to a psychiatrist for potential pharmacological interventions. The CFT is instructed to identify and address barriers to making appointments and update/create a crisis plan that addresses all risk factors across all functional domains.
- Trauma Procedures identify processes for youth who have a rating of a 2 or 3 on the CANS item *Adjustment to Trauma*, or youth with a history of emotional, physical, sexual abuse or neglect, or youth who have three or more Adverse Childhood Experiences (ACEs). When youth are receiving counseling from an LMHP, the WAF should obtain a release of information signed by the guardian for the LMHP, collaborate with the provider, encourage participation in CFT meetings, and include strategies for them in the Plan of Care. When youth are not receiving services from an LMHP, the facilitator should offer the CFT options for LMHPs in their area and assist them in selecting a provider. If there are barriers to finding an LMHP, the WAA notifies Magellan by the next business day to assist in finding a provider. If the family agrees to see the provider, a release of information is signed, and a referral is made within three business days. The facilitator follows up to ensure the appointment is made; if not, assistance is provided to the family to reschedule. When a family does not initially agree to see an LMHP, a strategy is added to the POC to bring in an expert to educate the family on the importance of addressing trauma and the evidence-based approaches used to treat it. Strategies should be added to the POC to discuss how trauma will be addressed and how the family will continue to be

educated on the benefits of using evidence-based approaches to address trauma if the family still does not agree to see an LMHP.

To assist WAAs in identifying youth who would benefit from implementing one or both of the above procedures, Magellan developed HI/SI and Trauma flags on the WAA Management Report using CANS and IBHA data. The report is distributed to the WAAs daily to track engagement with LMHP and EBP services, including FFT, Homebuilders, Prescriber Evaluation/Management, Psychiatric Evaluation, Outpatient Therapy, and Psychological Testing. The report includes the provider name, date of the most recent claim, and number of days with a claim in the previous 180 days to monitor utilization in real-time. The tables below provide the report specifications and the status of the youth enrolled in CSoC on 12/31/2022 (N = 2,339).

Table 7. WAA Management Report – Clinical Procedure Flags

Flag	CANS	IBHA Section #1 - Yes	IBHA Section #2 - Yes
SI/HI	▪ Suicide Risk: Rated 1+ ▪ Self-Mutilation: Rated 2+ ▪ Other Self Harm: Rated 2+ ▪ Danger To Others: Rated 1+ ▪ Sexual Aggression: Rated 2+ ▪ Fire Setting: 2+	Suicidal Homicidal Ideation ▪ Suicidal Thoughts ▪ Suicidal Attempts ▪ Suicidal Intent ▪ Suicidal Plans ▪ Homicidal Thoughts ▪ Homicidal Attempts ▪ Homicidal Intent ▪ Homicidal Plans	Risk Assessment ▪ Prior Suicide Attempt ▪ Stated Plan/Intent ▪ Prior Acts of Violence ▪ Harms Animals ▪ Fire Setting ▪ Arrests for Violence ▪ Prior hospitalizations for danger to others
Trauma	Adjustment To Trauma: Rated 1+	History of Trauma ▪ Experienced ▪ Witnessed ▪ Abuse ▪ Neglect ▪ Violence ▪ Sexual Assault	Other Risk Factors ▪ Feels unsafe in the current living environment ▪ Feels currently being harmed/hurt/abused/threatened by someone ▪ Past involvement with Child or Adult Protective Services

Table 8. WAA Management Report – Frequency Distribution on 12/31/2022

Areas of Need	Denominator	Percent
SI/HI Flag	2,339	66.6%
Trauma Flag	2,339	76.3%
Danger to Others = 2+	2,339	16.9%
Suicide Risk = 2+	2,339	9.9%

Magellan monitors POCs through care and utilization management reviews to support and assist facilitators in developing a POC that appropriately address trauma concerns and considers EBPs, as detailed below.

- **Routine POC Reviews.** Magellan Care Managers (CMs) monitor POCs at the initial enrollment and at least every 180 days after using a standardized review tool. When minimum standards are unmet, CMs provide an abbreviated WAA facilitation authorization (i.e., less than 180 days). The WAA must correct and resubmit

POCs to obtain full authorization. See Table 9 for definitions and coding guidance for EBP Considered when appropriate and Trauma concerns addressed.

- **Inpatient Staffings**. When youth are admitted to an inpatient psychiatric hospital, Magellan's clinical, quality, and medical staff, WAA Facilitators, and the Family Support Organization (i.e., youth and parent peers) participate in multidisciplinary staffings to review and refine POCs. The risk and trauma procedure implementation status is examined.
- **Root-Cause Analysis (RCA) Staffings.** Magellan's clinical, quality, and medical staff meet with the youth's WAF, the WAF's supervisor, and the WAA Clinical Director to conduct a more comprehensive barrier analysis when a youth is readmitted to an inpatient hospital within 60 days of a previous discharge. The staffings are intended to support WAFs in identifying factors that lead to readmission and prioritization actions needed to reduce the likelihood of future readmission.

Magellan monitors POCs through care and utilization management reviews to support and assist facilitators in developing a POC that appropriately address trauma concerns and considers EBPs, as detailed below.

Table 9. POC Review Tool – Coding Guidance

Item	Definition	Yes / Rating of 5	Rating of 3	No / Rating of 1	Exclusions
EBP is considered when appropriate	When an existing EBP is available to address identified needs, they are considered.	EBP is appropriate for the identified need, and a strategy assigned to the provider is congruent with the EBP's treatment model & team mission.	EBP is appropriate for identified needs, but the strategy is incongruent with the team mission or the EBP's treatment model.	EBP is appropriate for identified needs and is not considered by the team.	There are no EBPs available that address the identified need.
Trauma concerns addressed	When trauma concerns are identified in the assessment, the POC includes specific strategies to address them.	Strategies are specific to the type of trauma and identify specific methods that address the needs identified.		No strategies exist that address trauma.	The youth has no trauma concerns

Results

POC Review Tools were completed for a random sample of CSoC youth stratified by region and type of assessment (i.e., initial or reassessment) of approximately 75% of all POCs submitted during the measurement period. All POCs are reviewed using the same criteria, but 75% are entered into the tool. Baseline data were collected from 07/01/2019 to 06/30/2020, followed by the first remeasurement period from 07/01/2020 to 06/30/2021 and the second from 07/01/2021 to 06/30/2022.

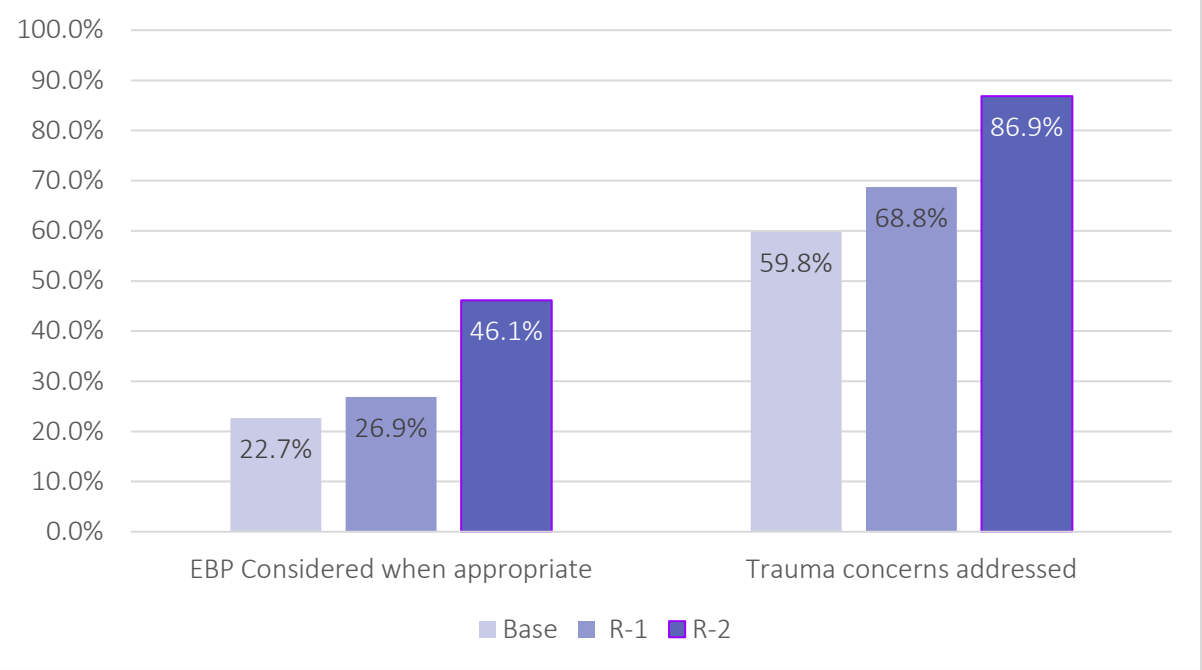
Table 10 and Figure 3 below depict the results of these reviews. The percentage of POCs that included considered the use of EBPs when appropriate increased from 22.7% (N = 3,937) to 46.1% (N = 2,259) from baseline to the second remeasurement, $X2$ (1, N = 6,196) = 376.3, < .00001. In addition, POCs addressing trauma concerns increased from 59.8% (N = 2,852) at baseline to 86.9% (N = 2,137) at the second remeasurement, which was a statistically significant improvement of 27.0 percentage points, $X2$ (1, N = 4,989) = 437.2, $p < .00001$. These steady

rate increases observed across remeasurement periods demonstrate the effectiveness of these initiatives to improve youth and family access to specialized, clinically-sound care.

Table 10. POC Review Tool EBP Indicators

	Baseline July 2019 – June 2020		Remeasurement 1 July 2020 – June 2021		Remeasurement 2 July 2021 – June 2022	
Indicator	Number	Percent	Number	Percent	Number	Percent
EBP is considered when appropriate	3,937	22.7%	2,655	26.9%	2,259	46.1%
Trauma concerns addressed	2,852	59.8%	2,701	68.8%	2,137	86.9%

Figure 3. POC Review Tool EBP Indicators



Intellectual/Developmental Disabilities

CSoC youth experiencing comorbid behavioral health and intellectual/developmental diagnoses require special coordination of services with the Office of Citizens with Developmental Disabilities (OCDD). OCDD serves as the Single Point of Entry (SPOE) into Louisiana's developmental disabilities services system and oversees public and private residential services and other services for people with developmental disabilities. The table below provides the number and percent of unduplicated CSoC enrollments enrolled in both CSoC and OCDD waivers in 2022, representing 1.7% of CSoC youth (N = 4,516). In addition, all CSoC youth are screened for potential intellectual and developmental disabilities during the clinical eligibility assessment and care management reviews.

Screening is crucial because OCDD waivers typically provide services across the lifespan, while the CSoC waiver services are only accessible to youth ages 5 to 20.

Table 11. CSoC and OCDD Dual Waiver Eligibility by Year

Year	Members Eligible	OCDD Waiver	Percent
2021	4,086	73	1.8%
2022	4,516	75	1.7%

Barriers

In 2019, the Quality Improvement Committee (QIC) identified an opportunity to improve the ability of POCs to address the developmental and educational needs of CSoC members. Quantitative data was collected through provider record reviews. Additionally, qualitative data was gathered through interviews with WAA leadership and facilitators during monthly videoconference meetings, weekly inpatient staffings, and high-complexity staffings. Common barriers include:

- Lack of caregiver and provider awareness of developmental/educational needs
- Stigmatization around IDD and mental health
- Diagnostic overshadowing – e.g., assuming behaviors that may be symptoms of IDD are part of the existing psychiatric diagnosis and vice versa
- Episodic presentation – symptoms are not currently present or not detected at the time of assessment
- Difficulty in obtaining information about what services are available
- Lack of clarity on referral pathways and how services are structured
- Fragmentation of behavioral health and IDD service systems

Interventions

To address the barriers above, Magellan elicited participation from the WAAs to develop a consensus-based clinical procedure to outline specific actions that should be completed to ensure needs are adequately addressed. The Developmental and Educational (D/E) procedure is described below. The procedure is informed by Wraparound principles and is meant to guide non-clinician Wraparound Facilitators in navigating the complex systems that support youth with educational and developmental needs.

- Wraparound Agency (WAA) should review all referrals and assessments to ascertain if the youth is enrolled in an OCDD waiver, has an Individualized Education Plan (IEP), 504 accommodations, or other educational needs.
- If OCDD has already approved the youth, information is released, and the Child and Family Team (CFT) reviews the current services received by the youth and family to determine whether other qualified services would be beneficial.
- If OCDD has not yet approved the youth, the WAF provides information about the agency, and a strategy is added to the POC to assist the guardian in making a referral through the local Human Services District.
- If the family does not initially agree to the referral, a strategy is added to the plan to consult an expert to educate the family on OCDD supports and services.

- If the youth has not previously had psychological testing, a referral is made and added to the POC.
- If the youth has a current IEP or 504 plan in place, a release of information is obtained for the school, and a copy of the IEP or 504 accommodations is requested. Data from the document is included in the family story and the POC. If current accommodations are not meeting the needs of the youth, a strategy is added to assist the family in requesting an updated IEP or meeting with the school.
- If the youth does not yet have an IEP or 504 but has a developmental disability or unmet educational need, a release of information is obtained for the school. A strategy is added to the POC to assist the guardian in making a written request for a School Building Level Committee meeting and indicates who will attend with the guardian. Subsequent POCs indicate other steps to be taken to ensure the youth's academic needs are met.

To assist WAAs in identifying youth who would benefit from implementing the D/E procedure, Magellan developed a D/E flag using diagnosis, eligibility, and CSoC Data spreadsheet data sources distributed to the WAAs daily via the WAA Management Report. The report also shows whether the youth has a developmental diagnosis, OCDD Waiver eligibility, and an Individualized Education Plan (IEP). This data can assist the WAA in monitoring the completion of the D/E procedure for youth with D/E actionable needs. The tables and figures below provide the report specifications and the status of the youth.

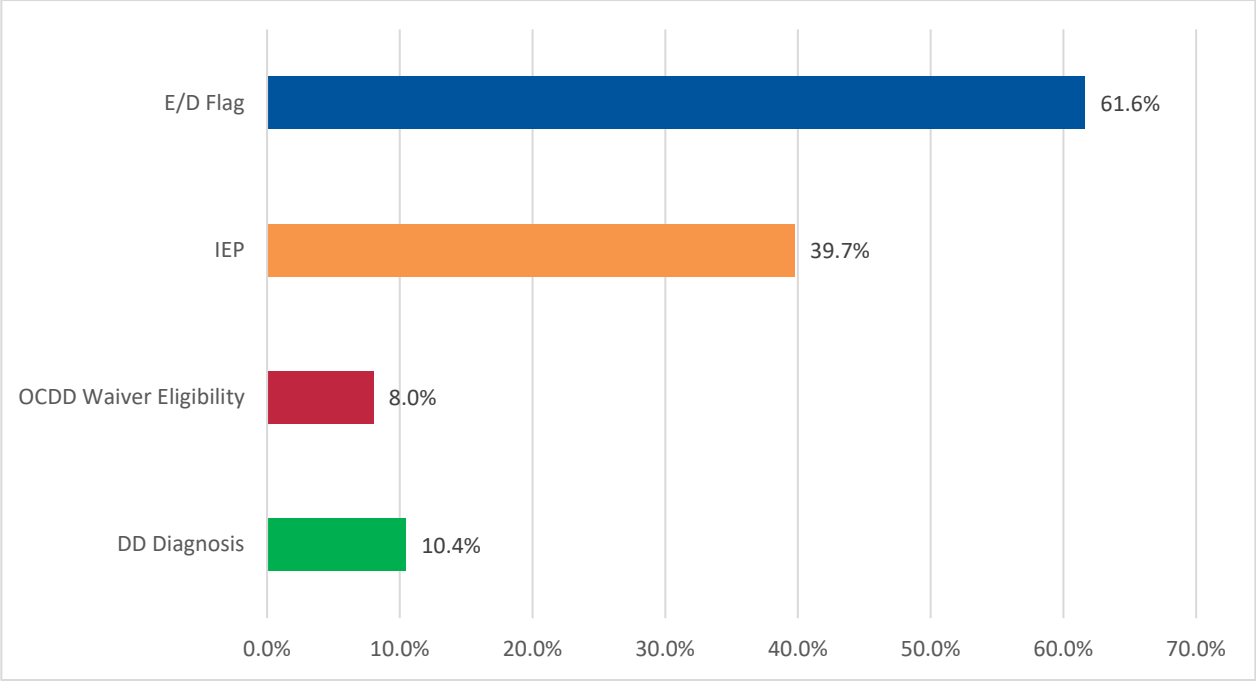
Table 12. WAA Management Report - Developmental / Educational Needs Section

Label	Data Source	Definition	Options
DD Diagnosis	Internal Member Record	Youth with a diagnostic code of F84.0, F84.9, F80.9, F89, F81.9, F88, F70, R41.83, F71, F72, F73 pm the initial WAA Authorization.	Y / N
OCDD Waiver Eligibility	Eligibility	OCDD waiver eligibility from LDH eligibility feed as of report run date. Blanks indicate no OCDD waiver. Waivers include: ▪ New Opportunities Waiver ▪ Children's Choice Waiver ▪ Residential Opportunities Waiver ▪ Supports Waiver ▪ Waiting for OCDD Waiver	▪ NOW ▪ Ch. Choice ▪ Res. Opp. ▪ Supports ▪ Chisolm
OCDD Case Management Agency	Eligibility	Name of the billing provider of the case management agency. Blanks indicate no OCDD waiver.	Provider Name or "Unknown"
Individualized Education Plan (IEP)	CSoC Data Spreadsheet	Status reported on the recent CSoC Data Spreadsheet data.	Y / N
E/D Flag	CANS & IBHA Assessment	Criteria for the E/D flags include any one of the following: ▪ CANS – Developmental Item: Rated 1+ ▪ CANS – School 8 Item: Rated 2+ ▪ IBHA – Difficulty reading and writing: Yes ▪ IBHA – Intellectual Functioning: Borderline	Y / N

Table 13. WAA Management Report – Frequency Distribution on 12/31/2022

Areas of Need	Denominator	Numerator	Percent
DD Diagnosis	2,339	244	10.4%
OCDD Waiver Eligibility	2,339	187	8.0%
IEP	2,114	840	39.7%
E/D Flag	2,339	1,441	61.6%

Figure 4. Developmental/Educational Needs of CSoC Youth on 12/31/2022



Magellan monitors POCs through care and utilization management reviews to support and assist facilitators in developing a POC that effectively addresses developmental/educational needs, as detailed below.

- **Routine POC Reviews.** Magellan Care Managers (CMs) monitor POCs at the initial enrollment and every 180 days using a standardized review tool. When minimum standards are unmet, the CMs provide an abbreviated WAA facilitation authorization (i.e., less than 180 days). The WAA must correct and resubmit POCs to obtain full authorization.
- **Inpatient Staffings.** When youth are admitted to an inpatient psychiatric hospital, Magellan's clinical, quality, and medical staff, WAA Facilitators, and the Family Support Organization (i.e., youth and parent peers) participate in multidisciplinary staffings to review and refine POCs. The D/E implementation status is examined when developmental comorbidities are present to identify barriers.

- Root-Cause Analysis (RCA) Staffings. Magellan's clinical, quality, and medical staff meets with the youth's WAF, the WAF's supervisor, and WAA Clinical Director to conduct a more comprehensive barrier analysis of the youth's POC and identify an action plan to resolve barriers to implementing the D/E procedure when youth are readmitted to an inpatient hospital within sixty days of discharge.

Magellan monitors the effectiveness of these interventions to improve the effectiveness of plans to address D/E actionable needs using the following POC Review Tool items:

- Strategies are present if the youth has failed a grade or has learning/developmental needs.
- If the youth is classified as Chisholm or OCDD, the youth is receiving DD services

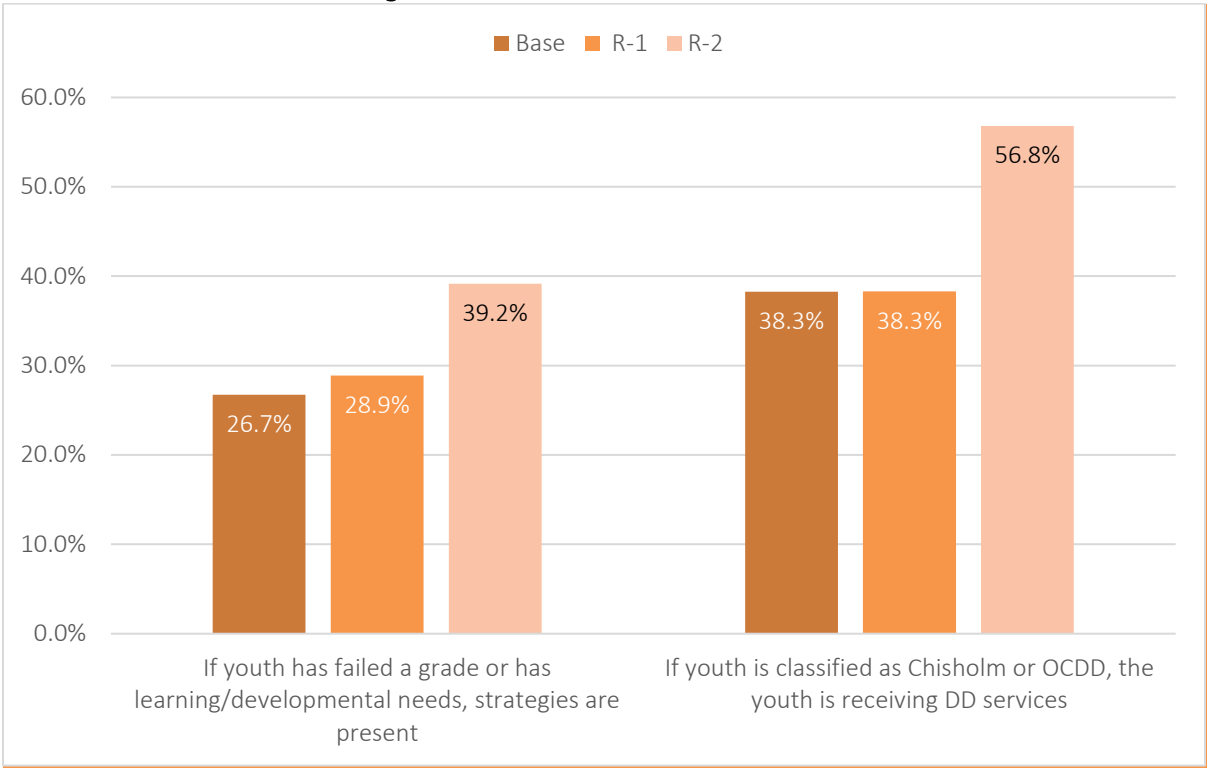
POC Review Tools were completed for a random sample of CSoC youth stratified by region and type of assessment (i.e., initial or reassessment) of approximately 75% of all POCs submitted during the measurement period. All POCs are reviewed using the same criteria, but 75% are entered into the tool. Baseline data were collected from 07/01/2019 to 06/30/2020, followed by the first remeasurement period from 07/01/2020 to 06/30/2021 and the second from 07/01/2021 to 06/30/2022.

Table 14 and Figure 5 below depict the results of these reviews. The percentage of POCs that included appropriate strategies when youth who failed a grade or had learning/developmental needs improved significantly, increasing from 26.7% (N = 2,757) to 39.2% (N = 2,651) from baseline to the second remeasurement, X2 (1, N = 5,408) = 94.6, < .00001. In addition, the percent of youth eligible for an OCDD waiver and receiving OCDD services increased from 38.3% (N = 371) at baseline to 56.8% (N = 250) at the second remeasurement, which was a statistically significant improvement of 18.5 percentage points, X2 (1, N = 5,408) = 20.7, p < .00001.

Table 14. IDD POC Review Tool Indicators

	Baseline July 2019 – June 2020		Remeasurement 1 July 2020 – June 2021		Remeasurement 2 July 2021 – June 2022	
Indicator	Number	Percent	Number	Percent	Number	Percent
If a youth has failed a grade or has learning/developmental needs, strategies are present	2757	26.7%	2934	28.9%	2651	39.2%
If a youth is classified as Chisholm or OCDD, the youth is receiving DD services	371	38.3%	308	38.3%	250	56.8%

Figure 5. IDD POC Review Tool Indicators



In addition to provider and member interventions, Magellan is committed to engaging with stakeholders to inform and advance policies that support the integration of behavioral health and IDD services systems. In 2022, Magellan's Medical Director, Dr. [redacted], played a role in various panels and workgroups seeking to identify how this population can better be served. Below is a summary of Dr. [redacted]'s efforts and planned activities for the future:

- Louisiana Dual Diagnosis Workgroup. Dr. [redacted] was selected to participate in an ongoing workgroup to evaluate and address the needs of youth with developmental disabilities and behavioral health diagnoses. The work group includes representatives from the Office of Citizens with Development Disabilities (OCDD), The Arc of Louisiana, and various people working within the DD community. Meeting bi-weekly throughout 2023, this group collaborated to create a first-of-its-kind provider guide to accessing resources for dually diagnosed youth and adults in the state. Co-authored by Dr. [redacted], this resource entitled *The Louisiana Guide to Providing Behavioral Health Services with Dual Diagnosis: A Guide for the General Clinician* will be distributed to providers and shared on Magellan's website following LDH approval.
- Guide for Families. While creating the provider resource guide, the workgroup identified the need for a family guide for those with developmental disabilities and behavioral health issues. This guide will significantly enhance families' knowledge of available resources, how to apply for assistance, and how to navigate DD and mental health systems. The guide is predicted to be completed in 2023.
- House Concurrent Resolution No. 38 (HCR 38) Workgroup. Dr. [redacted] was selected to participate in the workgroup established to implement bill HCR 38 of the 2022 regular legislative session. This bill was created to request that the Louisiana Department of Health (LDH) commence a study of the unique needs of

individuals with intellectual and developmental disabilities and co-occurring behavioral health conditions. The workgroup includes leadership from Magellan, the Arc of Louisiana, OCDD, Louisiana Medicaid, the Governor's Office of Disability, and parents of youth with developmental and behavioral health challenges. The group is tasked with identifying current deficiencies in access and resources for these citizens and designing systems and policies to resolve them. This workgroup is ongoing and will continue into 2023.

- **Presentation: Cross-System Collaboration: Bridging the Gap for Individuals and Families.** In December 2022, Dr. [redacted] and OCDD clinical leaders Drs. [redacted] and [redacted] presented at a national conference on the challenges in accessing services for youth with comorbid developmental and behavioral health conditions. The presentation addressed adverse outcomes when cross-system collaboration does not occur and practical strategies to improve cooperation and access to care. The presentation highlighted the collaborative relationship between Magellan and OCDD to ensure shared goals, training, eligibility, and resource linkages.

Disparities in Mental Healthcare

Numerous studies have evidenced disparities in access, use, and quality of behavioral health services among minority populations, individuals of low socioeconomic status, and those residing in rural areas, which can impact both mental and physical health outcomes. Barriers to accessing health services can include excessive costs associated with care, lack of insurance coverage, lack of transportation, and lack of services in one's community. The CSoC program, through the application and implementation of Wraparound practices, intrinsically and directly addresses many of the known disparities in mental health care and individuals experienced by CSoC enrollees. Specific actions taken to minimize or reduce disparities in CSoC include:

- All CSoC youth are assessed by a Certified Provider, a specially trained LMHP, at enrollment and at least every 180 days to ensure that the cultural and linguistic needs of CSoC youth and families are identified. Certified Providers must participate in at least three hours of Cultural Competency and complete CANS recertification annually. Assessment procedures require assessors to utilize the following assessment and screening tools to support the identification of behavioral health needs during the assessment process:
  - The CANS assessment is used to identify co-occurring disorders, substance use, physical health needs, acculturation/linguistic needs, and exposure to adverse social determinants of health
  - The Adverse Childhood Experiences (ACEs) questionnaire for the identification of trauma
  - The Columbia-Suicide Severity Rating Scale (C-SSRS), required as of September 1, 2022
- Every youth is provided a designated Wraparound Facilitator (WF) that guides the youth and family through the Wraparound process upon referral, during enrollment, and at discharge. Because cultural competence is one of the critical values of Wraparound, the required Introduction to Wraparound and Facilitation 101 trainings completed by all WAFs include materials that support understanding, valuing, and building on the family's unique culture. WAFs participate in at least three hours of Cultural Competency training each year, including specialized trainings for youth and families from Hispanic/Latino, Vietnamese, and Native American cultures. These trainings assist WAFs in supporting CSoC's diverse youth and families in connecting with formal and informal services necessary to address needs and reduce disparities in accessing care. In addition, Magellan hosted WAA Onboarding trainings in 2022 that all facilitators were required to attend. The topics covered were:
  - Motivational Interviewing
  - Autism Spectrum Disorder & ABA Therapy
  - Court Reporting

  - The Columbia Protocol

- Development and implementation of an individualized POC that includes sufficient supports and services to address member goals and health needs (e.g., risk behaviors, physical, functional, and behavioral health needs, etc.) must specify the amount and frequency of each service and identify the type of provider to furnish each service, including necessary Medicaid services and informal supports. The POC Review Tool is used to identify actionable needs for youth and families and ensure that they are met through the services provided. Magellan Care Managers monitor all member POCs at least every 180 days to evaluate that the identified strategies and interventions comply with waiver assurances, National Wraparound Initiative (NWI) best practices, principles of Wraparound, and LDH and Magellan requirements.
- Magellan provides a written, electronic report for each reviewed POC with ratings and individualized feedback when deficiencies are identified. Individual remediation is required when a plan does not meet established standards. In such a case, the WAF works with the CFT to revise the POC. The POC is then resubmitted and reviewed by the Care Manager to ensure standards are met before approval.
- WAAs survey youth and guardians at least monthly to ensure the POC is being implemented per their needs. If barriers are identified, the WAA provides individual remediation to support the youth and family.
- Magellan's Health Plan Care Coordination Liaison works with the youth's health plan to address physical health and pharmacy benefits issues, including difficulties accessing prescription medications, coordination of uncovered behavioral health services, and accessing a medical specialist.

As discussed throughout this section, CSoC engages with minority populations and connects them to essential healthcare services to address their behavioral health and substance use needs. One of the primary ways CSoC monitors the achievement of program goals and improvements in clinical functioning is through data collected during assessment processes. The CANS assessment is administered at enrollment, every 180 days after that, and at discharge from the program. Clinical improvement is a decrease of five or more points in a youth's global CANS score from initial to discharge assessments. The table and figures below present improved clinical functioning rates in 2021 and 2022.

Table 15. Improved Clinical Functioning by Race and Year

		2021		2022	
Category	Type	Number	Percent	Number	Percent
Race	Black / African American	797	71.3%	803	68.2%
	White	652	67.4%	733	64.3%
Gender	Female	631	69.4%	721	67.2%
	Male	913	69.2%	918	66.3%

Figure 6. Improved Clinical Functioning by Race and Year

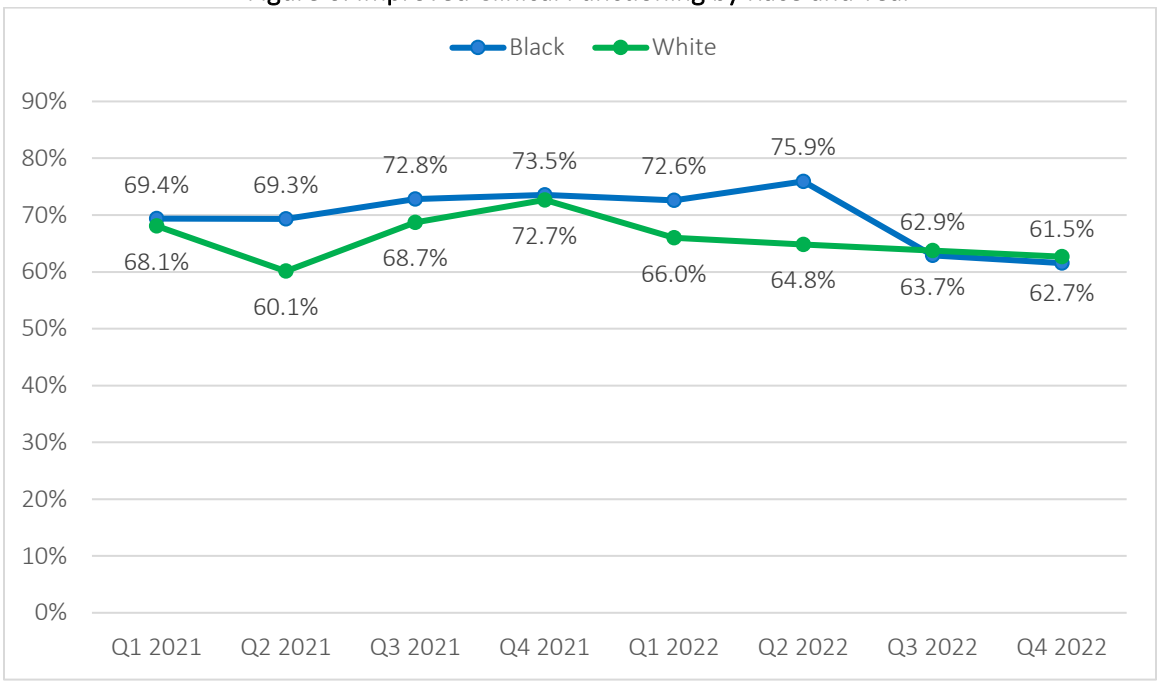
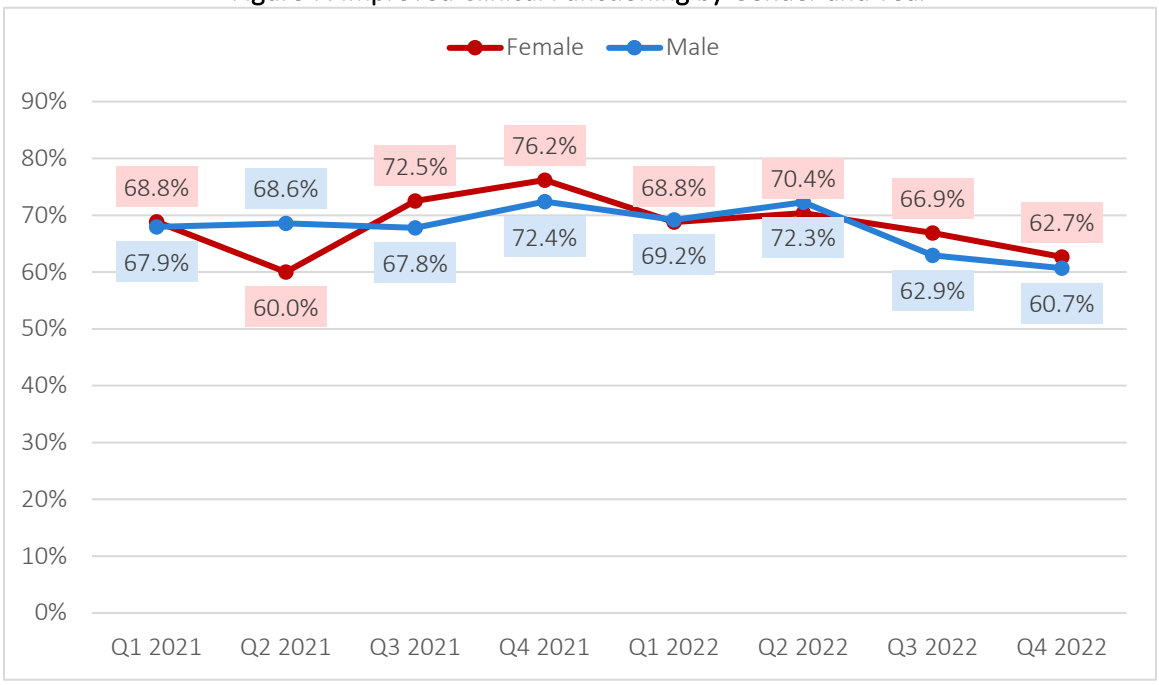


Figure 7. Improved Clinical Functioning by Gender and Year



Of youth discharging from CSoC in 2022, 71.9% demonstrated a CANS global score improvement of 5 or more points from the initial to discharge assessment (N = 1,383). When examining the results by the two largest racial groups, clinical improvement was seen in 68.2% of African American youth (N = 803), compared to 64.3% of

White youth (N = 733). A chi-square test of independence was performed to examine the relationship between the two groups and indicated no statistically significant difference, X2 (1, N = 1,536) = 0.099, p < .05. When examining the results by gender groups, clinical improvement was seen in 64.3% of male youth (N = 721), as compared to 66.3% of female youth (N = 918). The outcomes from the two groups were examined using the chi-square test of independence, which showed no statistically significant difference between Black and White youth. X2 (1, N = 1,639) = 0.109, p < .05. These findings provide confidence that once enrolled in CSoC, youth and families experience improved clinical functioning, regardless of race or gender. Please see the section of this evaluation for a comprehensive analysis of performance measures used to monitor CSoC outcomes.

Social Determinates of Health

The Social Determinates of Health (SDH) are closely tied to Healthcare Disparities, which are unique to each individual. Social determinants of health are the economic and social conditions in which individuals are born, grow, and live. These conditions significantly affect physical health outcomes, quality of life, safety, access to resources and education, and mental well-being. CSoC youth and families face these societal challenges daily. The CANS is administered at enrollment and at least every 180 days after that. The assessment includes the identification of specific social determinants of health impacting each youth and family. Magellan uses CANS data to identify areas of need for our membership and monitor the program's effectiveness to support youth and families in resolving those needs. This section describes ten social determinants of health commonly observed within the CSoC population and analyzes how the CSoC program helps youth and families address these determinants.

- Caregiver Knowledge. Access to healthcare information and resources by caregivers is vital in advocating for youth with emotional and behavioral disturbances. Unfortunately, healthcare literacy, which includes understanding mental health diagnoses, medication and treatment options, and services covered by one's insurance, is often lacking in underserved populations. Healthypeople.gov, a website promulgated by the Office of Disease Prevention and Health Promotion, reported in 2020 that "…uninsured and publicly insured (e.g., Medicaid) individuals are at a higher risk of having low health literacy…. Some of the greatest disparities in health literacy occur among ethnic minority groups from distinct cultural backgrounds and those who do not speak English as a first language."5 Magellan believes that the Wraparound principle of Family Voice and Choice cannot be fully realized without adequate health literacy, monitored using the CANS strength item *Caregiver Knowledge.*
- Relationship Stability. CSoC enrollment requires that youth be currently in or at risk of out-of-home placement, resulting in separation from family and community. Many youths in CSoC face the absence of a stable relationship with their parents or caregivers for various reasons, including incarceration, separation, divorce, removal from the home, and death. One way in which CSoC youth are assessed for need in this area is through the CANS Youth Strength item *Relationship Permanence.* A licensed clinician assesses youth to evaluate the number, strength, and permanency of their relationship with one or more caregivers.
- School Attendance & Achievement. Louisiana was ranked 47th in the nation for high school graduation rates in 2019 and 2020, with an 85.2% graduation rate in 2020. Youth with mental and behavioral disorders face

[5] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf
Office of Disease Prevention and Health Promotion. *Health Literacy.* Retrieved on 2/17/2022.

unique challenges in school and may require specialized interventions to achieve at the same level as their peers. Youth are often referred to CSoC by those in educational institutions, including teachers, principals, school counselors, and truancy monitoring entities. The educational needs of CSoC youth are assessed in multiple ways, but the most comprehensive measure is the CANS Life Domain Functioning Item *School*. Based on an assessor's rating of this item, which examines overall school performance, an additional assessment module is triggered if problems are identified. That module then assesses a youth's school needs in greater detail to direct treatment planning and guide individualized care.

- Optimism. Finding and maintaining hope is an essential component of mental health. The compound nature of disparities in social determinants of health has had a marked effect on levels of optimism. A central tenant of Wraparound is the belief that all youth desire to feel happy and loved within their family unit and community. The pandemic's limitations and isolation have seriously tested the limits of youths' ability to maintain an optimistic outlook. The COVID-19 vaccine was approved for use in youth aged 12-15 in May 2021 and 5-11 in October 2021. Before this, uncertainty permeated the daily lives of youth and adults alike. The CANS item *Optimism* measures how youth can maintain a robust and stable outlook on life.
- Stress. An analysis by LDH spanning 2016-2020 states that 13% of Louisiana residents report feeling frequent mental distress. Stress negatively impacts all aspects of life function, including physical health, behavioral health, social relationships, and educational performance.5F[6] Families enrolled in CSoC typically experience many stressful events related to their behavioral health conditions, such as psychiatric hospitalization, involvement with government agencies, and separation from family separations.
- The impact of stressful events on the youth and caregiver is assessed through the CANS Caregiver Family Stress item, which evaluates if the caregiver can manage the stress level associated with their youth's needs. A rating that indicates a need for action conveys that stress is interfering with or preventing the ability of the caregiver to parent entirely.
- Access to Educational Opportunities. Many social and economic factors can impact an institution's ability to educate its students, including adequate staffing, special education programs, geographic location, teacher-to-student ratios, and state funding. The CANS Youth Strength item *Education* evaluates the degree to which a youth's school addresses their educational needs. An assessment that indicates that a school cannot adequately address those needs triggers specific actions on the part of the CFT.
- Recreation: Talents & Interests. A key component in assessing social determinants of health is identifying healthy behaviors contributing to overall physical and mental well-being. One healthy behavior measured via the CANS is the Youth Strength item *Talents & Interests.* CANS ratings that evidence significant strength in this area indicate that a youth has identified talents, interests, or hobbies that provide him or her with pleasure and positive self-esteem. An absence of talents, interests, or hobbies is considered an actionable need that must be addressed in the POC.
- Access to Social Supports. The Wraparound model is built on a team-based approach. Caregivers of youth with severe mental and behavioral problems can often feel isolated, misunderstood, and unable to connect socially. Magellan prioritizes building a social support network for families they can rely on well after discharge from the CSoC program. A caregiver's level of support is assessed via the CANS Caregiver item

[6] University of Wisconsin Population Health Institute. County Health Rankings State Report 2019

Social Resources, which evaluates whether a caregiver has significant social ties to family, friends, neighbors, or other social networks that actively help raise their child.

- **Exposure to Trauma.** Trauma has long been a focus of mental health treatment, with practitioners and researchers have identified that unresolved trauma often underlies emotional and behavioral dysfunction. As the pandemic has lingered, so has the evidence of both individual and collective trauma permeating the lives of American youth. In 2021, the US Surgeon General released a report entitled *Protecting Youth Mental Health* detailing the realities of the continuing COVID-19 pandemic.[7] The report cites skyrocketing inpatient psychiatric admission rates, Emergency Department visits for mental health and much higher rates of youth self-reporting depression and anxiety.

  Further, the report notes that groups who have already experienced the negative impacts of Social Determinates of Health, such as low-income, rural, LGBTQI+, and youth involved with child welfare agencies, face compounded effects of trauma. One potential positive of the COVID-19 pandemic may be the recognition by state and federal governments that allocating resources to identify and treat trauma in youth is essential to the nation's recovery. At a minimum of every six months, CSoC's Certified Providers assess each youth for evidence of adjustment problems associated with traumatic life events. Magellan has taken many steps to ensure that when trauma impacts youth functioning, it is thoroughly documented and promptly addressed with strategies and interventions. A key focus of the ART is the *Adjustment to Trauma* CANS item. Magellan LMHPs review CSoC assessments to ensure that, when this need is rated as actionable, it is accompanied by clinical documentation of symptoms and targeted treatment recommendations for the Child & Family Team.

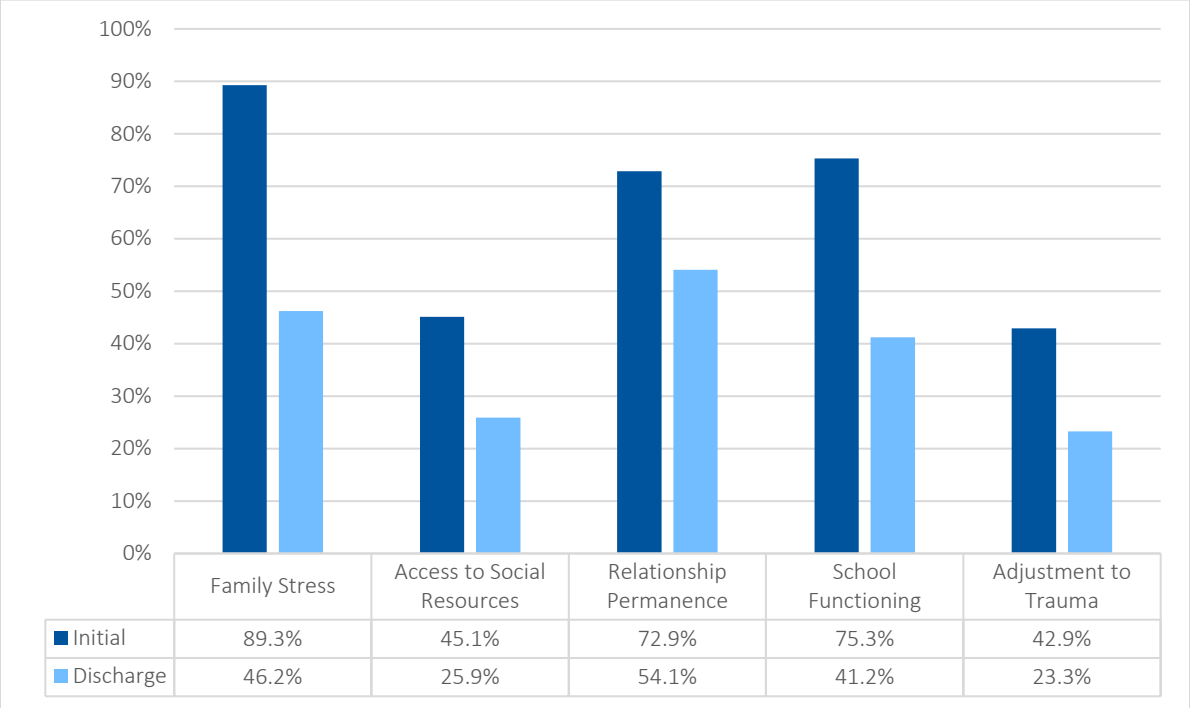
- **Coping Skills & Resiliency.** A key component of behavioral and mental health treatment is replacing maladaptive thoughts and actions with positive ones. Because of the intense, targeted nature of the CSoC program, developing coping skills is paramount to successful outcomes. Individuals with effective coping skills are self-reliant, able to problem-solve, and better equipped to make informed life decisions. The CANS Youth Strength item *Resiliency* assesses how youth can identify and utilize their internal strengths and resources. Lower ratings of need on this item indicate a youth who can successfully manage complex challenges in life by using positive coping skills.

Analysis

The effectiveness of the CSoC program in countering negative impacts of social determinants of health is monitored by comparing the prevalence rates of actionable needs and strengths items at the initial and discharge CANS assessments. An actionable need is defined as a CANS item with a rating of 2 or 3. These ratings indicate that the youth and family require treatment or intervention. Figure 8 below presents the quantitative change rate between initial and discharge actionable need prevalence in a subset of CANS items used to measure common social determinants of health in 2022.

[7] US Surgeon General Advisory: Protecting Youth Mental Health. Retrieved on 2/17/2022. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Figure 8. Reduction in Prevalence of Actionable Needs 2022



	Family Stress	Access to Social Resources	Relationship Permanence	School Functioning	Adjustment to Trauma
Initial	89.3%	45.1%	72.9%	75.3%	42.9%
Discharge	46.2%	25.9%	54.1%	41.2%	23.3%

To analyze CSoC's success in reducing the actionable needs of youth in 2022, the percentage of youth evidencing actionable needs at initial assessment (N = 1,792) and discharge assessments (N = 1,453) are compared. As indicated in the figure above, the prevalence of actionable needs identified on the CANS was markedly reduced from initial to discharge assessments for all items chosen for their relation to Social Determinants of Health. The most significant reduction in need was seen in *Family Stress*, which fell by 43.1 percentage points, which shows CSoC caregivers improved their ability to manage the stress of youths' needs and increased their ability to parent effectively. Youth with actionable needs for *Access to Social Resources* decreased from 45.1% at initial assessment to 25.9% at discharge, which provides evidence of the effectiveness of CSoC in connecting youth and families with adequate social resources and community supports.

Assessing and addressing trauma in CSoC youth was a focus in 2022. Assessor trainings and ART monitoring activities were designed to improve the quality of trauma assessment and documentation in youth assessments. A thorough evaluation of the impact of trauma symptoms on youth functioning is vital in linking youth and families to proper providers and treatment modalities. As the above graph shows, the prevalence of youth entering CSoC with actionable need on the CANS item *Adjustment to Trauma* was 42.9%, nearly half of the CSoC population. By the time of discharge, that prevalence was reduced to 23.3%. Efforts to identify and address trauma are ongoing, and evidence of progress is apparent in ART outcomes. Still, identifying trauma and evaluating its impact on youth functioning remains a top priority, and targeted trainings for assessors are planned for 2023.

A reduction of 34.1 percentage points was observed in the actionable need prevalence rate for the CANS item *School Functioning*, indicating a marked improvement in youths' school attendance, behavior, and achievement. Given that nearly all CSoC youth are school-age, educational outcomes are vital in evaluating the program's effectiveness.

Figure 9. Improvements in Strength Items 2022

	Resiliency	Talents/Interests	Educational	Caregiver Knowledge	Optimism
Initial	93.6%	63.3%	58.6%	43.2%	78.0%
Discharge	56.1%	33.9%	33.9%	18.7%	44.2%

As shown in the figure above, the most significant improvement observed in 2022 was in Resiliency, with 93.6% of youth evidencing the need for increased resiliency at intake and only 56.1% at discharge. This means that the rate of youth reported to have either no identifiable resiliency strengths or no ability to utilize that strength effectively was reduced by 37.5 percentage points from initial to discharge assessments. Significant improvement was observed in ratings of the CANS item Educational, which measures the ability of a school to work with the youth and family to identify and successfully address educational needs. Wraparound facilitators often lead in advocating for youth during IEP meetings and interacting directly with schoolteachers and counselors. In 2022, 58.6% of youth were assessed to have a school that was unable or unwilling to address their educational needs adequately. At discharge, that rate was reduced to 33.9%, a change of 24.7 percentage points.

Another marked improvement was observed in CANS ratings for Optimism, a noted protective factor. At the initial assessment, 78.0% of CSoC youth were rated as having low levels of optimism that warranted intervention. At discharge, this prevalence rate was reduced to 44.2%, a reduction of 33.8 percentage points. The ability of CSoC to impact levels of optimism significantly illustrates the magnitude of Wraparound's impact on youths' outlook and hope for the future.

Actions Taken

- All CSoC youth are assessed by a licensed practitioner using the CANS and the Individual Behavioral IBHA at their initial intake and at least every 180 days after that.
- The Quality Department utilized the Assessment Review Tool (ART) for four quarters in 2022, with 307 assessments reviewed. Significant improvements were observed in sections of the assessment related to

documentation of youths' response to treatment, evaluation of trauma, and recommendations for treatment modalities and strategies.

- The POC Review Tool is used to identify actionable needs for youth and families and ensure that they are met through the services provided. Magellan Care Managers monitor all member POCs at a minimum of every 180 days to evaluate whether strategies and interventions are consistent with identified needs, including those related to social determinants of health.
- In 2022, Magellan continued the use of the Adverse Childhood Experiences screening tools to identify the potential effects of trauma on youths' ability to function at home, at school, and within the community.
- In September 2022, Magellan made mandatory the completion of the Columbia-Suicide Severity Rating Scale (C-SSRS) at every eligibility assessment. Magellan trained Certified Providers on the purpose and administration of the tool in identifying youth at increased risk for suicide. Documentation of the administration of the C-SSRS is monitored by both Magellan's Independent Evaluator and via the ART.
- Magellan's website publishes a Behavioral Health Toolkit for Providers which includes educational materials, screening tools, and CPGs, for various behavioral health conditions.
- Magellan collaborated with WAAs to conduct a presentation at the 2022 annual TCOM Conference on the topic of assessing the CSoC youth population, from both administrative and clinical perspectives, in the time of COVID-19. The presentation was a joint effort between Magellan's Clinical Project Managers and a Certified Provider with years of experience assessing CSoC youth.

Recommendations for 2023

- ART reviews and collaborative calls will continue throughout 2023. The focus of ART reviews will be narrowed to a reduced number of critical items identified as needing improvement, including proper diagnosis, risk factor documentation, screening tool usage, and other categories critical to the development of the POC.
- In 2023, SDHs will be the focus of an All-Assessor Call. Training will include identifying SDHs, their prevalence in the Louisiana Medicaid youth population, and how to adequately assess their impact on youth and family functioning.
- In 2023, training plans will include collaboration with Magellan's Senior Trainer for guidance on topic selection and training techniques.

Culturally Competent Care

Magellan builds its programs and processes around an expansive definition of cultural competency in healthcare. It is expected that providers possess the capability to effectively render services that meet the cultural, social, and linguistic needs of all CSoC members. When youth and families feel heard and understood by providers, they are more likely to actively engage and participate in treatment, which in turn positively impacts member outcomes. Both the Wraparound model and Magellan's CSoC program design are founded upon culturally competent values, observable in the full continuum of enrollment, from initial assessment to transition of care at discharge. In a culturally based Wraparound model, families exercise choice over the services they receive, and the treatment team understands and values the family's theory of change. Magellan supports the facilitation of members' freedom of choice in providers that are respectful and inclusive of their cultural needs and preferences.

Magellan collaborates with care providers that respect the diverse backgrounds of the individuals and families served. Treatment modalities must acknowledge and support the behaviors, ideas, attitudes, values, beliefs, and languages of the individuals served. Magellan provides access to a comprehensive resource kit to support its provider network at MagellanProvider.com. This resource kit contains a variety of assessment tools, guidelines,

standards, and resources designed to assist providers, agencies, and the Magellan organization in enhancing cultural and linguistic competency throughout the behavioral healthcare system. Magellan developed training modules specific to Louisiana's cultural makeup and monitored Direct Care Staff to ensure annual cultural competency training requirements were met. Magellan's QIA agenda also includes a standing item to address emerging cultural competency needs. The following cultural competency trainings and resources are available on the Magellan website:

- **Cultural Competency Resource Kit:** Provides training and information for cultural competency concepts and applications, including assisting providers in developing a Cultural Competency Plan
- **Cultural Competency Training Modules:** a) The Hispanic/Latino Community in Louisiana; b) Louisiana Native American Indian Tribes; c) Vietnamese in Louisiana; and d) Why Cross-Cultural Competency? e) Serving and Supporting LGBTQI+ Youth in CSoC

Utilizing the materials in this kit, practitioners may conduct a self-assessment of provider-level cultural competence, assess organizational strength and growth related to cultural competence, and conduct member evaluations of healthcare provider cultural competency. In addition, various tools and resources are included to assist provider agencies in developing realistic and incremental organizational cultural competency plans. Some of the key areas addressed in the kit are detailed in the table below.

Table 16. Cultural Competency Resource Kit

Cultural Competence Guidelines and Standards	Key Components of Organizational Cultural Competence
▪ American Psychological Association, Guidelines on Multicultural Education Training, Research, Practice, and Organizational Change for Psychology www.apa.org ▪ Department of Health and Human Services Cultural and Linguistic Competence Standards http://minorityhealth.hhs.gov/ ▪ SAMHSA Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups http://nrchmh.org/ResourcesMHAdminsLeaders/Cultural%20Competence%20Standards%20SAMHSA.pdf ▪ Association of Multicultural Counseling and Development (AMCD) Multicultural Counseling Competencies ▪ National Association of Social Workers, Standards for Cultural Competence in Social Work Practice http://www.naswdc.org/practice/standards/NASWculturalstandards.pdf.	▪ Organizational Cultural Competence Assessment Tools ▪ Multicultural Competence Service System Assessment Measure ▪ Organizational Cultural Competence Plan Template ▪ Strategies for Completing the Cultural Competence Plan ▪ Sample Cultural Competence Action Plan 18 ▪ Clinician/Service Provider Cultural Competence Measures ▪ The Multicultural Awareness-Knowledge-Skills Survey ▪ Cultural Competence Self-Test ▪ Cultural Competence Information Sheets ▪ Cultural and Linguistic Definitions ▪ Web Resources ▪ Cultural Competence-Related Books

Program Effectiveness in Addressing Member Needs

The QIC analyzes the information presented in this report each quarter to ensure the network's adequacy in meeting our members' needs. Some of the key member and provider characteristics assessed in 2022 included:

- The CSoC population is composed entirely of youth, with 78.8% of members between the ages of nine and seventeen.
- Males account for most CSoC youth, comprising 56.7% of the total enrollment.
- Black/African American youth account for 56.2% of total enrollment.
- ADHD is the most prevalent primary diagnosis of youth in CSoC, accounting for approximately 37.4% of total enrollment.
- Most practitioners (52.1%) identify as White/non-Hispanic and speak English as their primary language (98.2%).
- A diagnosis related to a developmental disorder was present in 10.4% of CSoC members in 2022.
- Developmental Disability waiver services (OCDD) are received by 1.7% of CSoC members.
- The percentage of CSoC youth involved with a child-serving state has increased since last year. As of the most recent evaluation, 12.1% and 9.0% of youth had DCFS or OJJ involvement, respectively.
- The 2022 Provider Satisfaction Survey found that 96% of providers reported positive or neutral overall satisfaction with Magellan.

In addition to the activities detailed in this report, Magellan implements a multi-dimensional monitoring process to ensure members have access to culturally competent services from all perspectives of care.
Data gathered through member services, care management, utilization management, quality monitoring, patient safety, and network monitoring activities are examined to determine the CSoC effectiveness of the program in providing culturally competent care for youth and families enrolled in CSoC. A summary of these activities is provided below.

- Requests for Interpretative/Translation Services: In 2022, Magellan utilized Voiance to interpret twelve telephone calls, of which 100% were for Spanish to English. Magellan received and processed 174 requests for interpretation or translation services, 160 of which were for Spanish to English and fourteen of which were for American Sign Language. There were no complaints reported against Voiance or International Languages. Results from the Member Experience of Care survey and Treatment Record Reviews conducted in 2022 indicate that the provider network is sufficiently meeting the linguistic needs of the CSoC enrollees.
- Member Grievances: We received no reported grievances involving cultural needs.
- POC Review Tool Items: Cultural competency is a core principle of Wraparound. This principle implies that the CFT will strive to ensure that the service and support strategies included in the Wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. Magellan CMs monitor adherence to this principle through the POC Review Tool as described below:
  - Family Story. The family story provides the contextual framework for all elements of the wraparound process and documents the strengths, assets, resources, needs, individual requirements, cultural norms, preferences, and the family's theory of change. The family story presents a balanced

perspective of the family's experience, including the family's theory of change. When a Family Story is omitted, the WAA must submit a corrected POC Family Story to receive prior authorization for Wraparound Facilitation. In 2022, 98.1% of POCs reviewed included the Family Story (N = 3,303).

- **Strategies unique to the family's culture, skills, and abilities.** The team will strive to ensure that the service and support strategies included in the wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. The principle requires that team members are vigilant about ensuring that culturally competent services and supports extend beyond wraparound team meetings. Results from POC Review Tools conducted in 2021 and 2022 were analyzed to ensure adherence with this principle, with 99.5% of plans and 99.8% of crisis plans showing compliance. In the past two years, over 99% of Plans of Care have evidenced that youth and family culture is supported and highly valued.

Table 17. POC Review Tool - Youth and Family Culture Items

POC Review Tool Item	Year	Numerator	Denominator	Compliance Rate
POC includes the family story	2021	3,738	3,810	98.1%
	2022	3,248	3,303	98.3%
POC strategies unique to the family's culture, skills, abilities	2021	3,809	3,810	100%
	2022	3,297	3,303	99.8%
Crisis Plan individualized to youth and family's culture, preferences, strengths, and needs	2021	3,789	3,810	99.7%
	2022	3,286	3,303	99.5%

Table 18. Treatment Record Review Results – Culturally Competent Care

Provider Type	Treatment Record Review Element	Records in Compliance	Total Records Reviewed	Compliance Rate
FSO	Evidence of services being provided in a culturally competent manner	103	103	100%
Formal BH Providers	The cultural needs (i.e., racial, ethnic, and spiritual/religious needs) of the member were assessed.	65	65	100%
	Identified cultural needs of the member were incorporated into treatment, if applicable.	13	13	100%

- **Member Experience of Care Survey**. Magellan administers an annual survey to assess youth and caregiver experience of care in CSoC. The survey results from 2021 and 2022 are detailed below. In 2022, youth and caregivers who responded positively represented 95.4% of the response group, which was an increase of 0.9 percent.

Table 19. Member Experience of Care Survey Results

Item	Year	Number	Positive	Neutral	Negative
Magellan's healthcare providers respect my family's cultural and language needs.	2021	293	94.5%	2.7%	2.7%
	2022	281	95.4%	3.9%	0.7%

Based on the data and analyses presented in this report, Magellan believes the CSoC network is meeting the needs of its members. In 2023, the CSoC Unit will continue to actively address opportunities for improvement through interventions to improve further the network's capacity to meet the needs of the CSoC members. Magellan has identified three subpopulations that would benefit from increased focus in the coming year: members requiring inpatient hospitalization, members with developmental disabilities, and those identifying as LGBTQI+. Planning is underway to enhance assessors' ability to evaluate and support the unique needs of these groups. Senior quality, clinical, network, and medical leadership are continually involved in reviewing our QI program and collaborative initiatives to provide the best care possible for CSoC youth and families.

Appendix B. Compliance Review Remediation Follow-Up

Appendix B includes Magellan's responses to the CAP recommendations made by the previous EQRO for addressing deficiencies from the prior year's compliance review, and HSAG's findings after reviewing Magellan's responses and additional documentation. Please note that the responses in this section were provided by the PIHP and have not been edited by HSAG.

Recommendations
Requirement: *Requests for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.* This requirement is not addressed in any policies or procedures. During the interview, Magellan indicated that they will include this requirement in a future policy. Magellan also indicated that there were no requests requiring LDH approval during the review period. Magellan should include this requirement in a policy or procedure.
Response
Describe initiatives implemented based on recommendations: The provision is addressed via the Network Strategy Program Description document via page 6.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *There shall be no penalty if the member chooses to travel further than established access standards in order to access a member's provider of choice. The member shall be responsible for travel arrangements and costs.* This requirement is not addressed in any policies or procedures. During the interview, Magellan indicated that they will include this requirement in a future policy. Magellan also indicated that there were no requests requiring LDH approval during the review period. Magellan should include this requirement in a policy or procedure.
Response
Describe initiatives implemented based on recommendations: The provision is addressed via the Network Strategy Program Description document via page 6.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified

Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Contractor shall ensure access to healthcare services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care, facility wait list) in accordance with the provision of services under this contract and in accordance with 42 CFR §438.206(c). The Contractor shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, and professional personnel for the provision of services, including all specialized behavioral health emergency services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:* • *Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses, or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in rural parishes shall not exceed thirty (30) miles or sixty (60) minutes, whichever is less, for one hundred percent (100%) of members.* • *Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses, or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in urban parishes shall not exceed fifteen (15) miles or thirty (30) minutes, whichever is less, for one hundred percent (100%) of members.* • *Travel distance to specialized behavioral health outpatient non-MD services (excluding behavioral health specialists) shall not exceed sixty (60) miles or ninety (90) minutes, whichever is less, for urban members and ninety (90) miles or one hundred and twenty (120) minutes, whichever is less, for rural members. Maximum time for appointment shall not exceed appointment availability requirements for specialized behavioral health emergent, urgent, and routine care.* This requirement is partially addressed, as the network does not fully meet the LDH PIHP Network Standards for all practitioner types in all parishes. Magellan should continue to comply with the requirements detailed in the Network Development and Management Plan by contracting with additional providers where available.
Response
Describe initiatives implemented based on recommendations: The provision is addressed via the Network Strategy Program Description document via page 6. LDH has revised and approved specific language to the provision. The plan has updated the policy accordingly to meet the recommendation by LDH.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.

HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Contractor shall develop and maintain a care management function that ensures covered behavioral health services are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and be in compliance with 42 CFR §438.210. The care management system shall have LMHP care managers (CMs) that respond twenty-four (24) hours per day, seven (7) days per week, and three hundred and sixty-five (365) days per year to members, their families/caregivers, legal guardians, or other interested parties calling on behalf of the member. Failure to meet this standard as verified by LDH will subject the Contractor to remediation outlined in Section 18 of this contract.* The requirement is partially addressed by the Accessibility of Service and Care Policy, which specifies access of service and care to members, but not their families/caregivers, legal guardians, or other interested parties calling on behalf of the member. Magellan should update the policy to include the missing language from the state contract.
Response
Describe initiatives implemented based on recommendations: The Accessibility of Service and Care Policy has been updated to include the missing language from the state contract via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Ensure the WAA will provide quick access to Wraparound care coordination. It is expected that the WAA will attempt to contact the youth/family within forty-eight (48) hours of the date of referral to the WAA. This will be measured through documentation on the monthly CSoC data spreadsheet. The WAA staff will make face-to-face contact with the youth/family within seven (7) calendar days of WAA referral, which will be tracked through the CSoC data spreadsheet or as required in the CSoC Quality Improvement Strategy (QIS).* This requirement is partially addressed by the CSoC Data Spreadsheet and Referral Workflow. Magellan should create a policy or procedure to address this state contract requirement.
Response
Describe initiatives implemented based on recommendations: The Accessibility of Care Procedures have been developed to address this state contract review via page 2. The procedure is pending LDH-OBH approval.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Maintain and operate a formalized discharge planning program, including planning for discharges against medical advice. Provide information to members regarding walk-in clinics and crisis services prior to discharge from a facility providing 24-hour levels of care. Expedite approval of services for members being discharged from a 24-hour facility. Ensure the discharge planning process is initiated at admission and finalized at least twenty-four (24) hours before the scheduled discharge. Coordinate discharge and transition of members in an out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community including the referral to necessary providers. Ensure members receive follow-up appointment within seventy-two (72) hours with the appropriate behavioral health provider following discharge. Follow-up with members who are discharged from facilities providing 24-hour levels of care within seventy-two (72) hours post-discharge to ensure access to and attendance at aftercare appointments.* Of the 20 files reviewed, four (4) files met the requirement and 16 files were not applicable. This requirement is partially addressed by the Coordination with Inpatient Psychiatric or Detox Facility Policy and the Care Coordination with ER Policy. Magellan should update the policies to include the missing language from the state contract.
Response
Describe initiatives implemented based on recommendations: The Care Coordination with Inpatient Psychiatric or Detox Facility Policy has been updated to include the missing language from the state contract via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations
Requirement: *Refer members to appropriate network providers and/or community resources offering tobacco cessation treatment and/or problem gaming services, if the Contractor becomes aware of problem gaming and tobacco usage during an individual needs assessment or case review.* This requirement is partially addressed by the Tobacco Cessation and Problem Gaming Network Providers Resources document. Magellan should create a policy or procedure to address this state contract requirement.
Response
Describe initiatives implemented based on recommendations: The Tobacco Cessation and Problem Gaming Procedure addresses the state contract requirement via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Development of an individualized comprehensive plan of care by the Wraparound Facilitator which must be in compliance with applicable federal waiver requirements, based on the results of the member's individual assessment and System of Care principles and values, and shared timely with service providers. The Wraparound Facilitator shall collaborate with the member and his/her family to identify who should be involved in the plan of care planning process and develop and implement the plan through a person-centered process by which the member and his/her family has a primary role. The plan of care must include the following elements at a minimum: Member demographics; Identification of the member's providers; Member's goals, identified strengths and needs, and identified barriers to treatment; Supports and services, including type, frequency, amount and duration needed to meet the member's needs; and Plan for addressing crisis to prevent unnecessary hospitalization, incarceration, or out-of-home placement. The crisis plan must identify resources and contact information.* Of the 20 files reviewed, all 20 files met the requirement. This requirement is partially addressed by the Medicaid Care Coordination Policy, the Accessibility of Service and Care Policy, the Plan of Care Review Policy, the Plan of Care Review Tool, and the blank CSoC Plan of Care form. Magellan should update the policies to include the missing language from the state contract.
Response
Describe initiatives implemented based on recommendations: The Plan of Care Review Policy has been developed to include the missing language from the state contract via page 2. The policy is pending LDH-OBH approval. The POC Form Tool and POC Review Tool Coding Guide is included to meet the fulfillment of the state requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.

Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Documentation that freedom of choice of services and providers were offered to the member and his/her caregiver by the Wraparound Facilitator.* This requirement is partially addressed by the CSoC Freedom of Choice form. The CSoC Freedom of Choice form is a tool of implementation; however, a policy, procedure, or program description is needed to demonstrate how staff are instructed to execute the requirement. Magellan should create a policy or procedure to address this requirement.
Response
Describe initiatives implemented based on recommendations: The Magellan Health Referral Procedure has been updated to addresses the state contract requirement via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Contractor and the Integrated Medicaid Managed Care Program Plans shall work together to develop a single process for bidirectional information exchange related to shared members. The process will delineate the necessary information to be exchanged, timelines for information exchange, events and conditions that will trigger information exchange, data sharing format(s) and Information Technology (IT) requirements. The process and any changes to the process must be approved by LDH prior to implementation.* This requirement is partially addressed by the Information Exchange Procedure. Magellan should include the missing language in the Information Exchange Procedure detailing the timeline for information exchange, the data sharing format, and the Information Technology requirements.
Response
Describe initiatives implemented based on recommendations: Magellan will establish bidirectional Secure File Transfer Protocol (SFTP) for information exchange related to shared members and other sensitive data. The Medicaid Care Coordination policy has been updated to address the state requirement via page 8.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): Secure File Transfer Protocol (SFTP) is a network protocol for securely accessing, transferring and managing large files and sensitive data. Advantages of SFTP include the following: **Security -** SFTP enables data security, encryption and public key authentication, which protect data in transit. The security makes SFTP a reliable file transfer option. **Speed -** SFTP supports large file transfers and transferring multiple files from one server to another simultaneously. **Integration -** SFTP integrates well with VPNs and firewalls. **Management -** SFTP can be managed through a web interface or an SFTP client.
Identify any barriers to implementing initiatives: There are some initial complexity processes involved in setting up new SFTP connection. Magellan will need cooperation from the other party to provide us with some technical information in order to establish this connection.
Identify strategy for continued improvement or overcoming identified barriers: We will conduct some trainings so all participants will be comfortable using this new method for exchanging information.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Contractor Care Managers shall utilize secure email to provide notice to referring Integrated Medicaid Managed Care Program Plan Care Manager that information was received, and will contact the Integrated Medicaid Managed Care Program Plan Care Manager within three (3) business days of receipt of referral for routine referrals and within one business day, if referral is marked "urgent".* Of the 20 files reviewed, two (2) files met the requirement; 18 files were not applicable due to referrals occurring before the review period or being direct referrals. This requirement is partially addressed by the Referral Workflow. Magellan should create a policy or procedure that addresses the state contract requirement.
Response
Describe initiatives implemented based on recommendations: The Magellan Health Referral Procedure has been updated to address the state contract requirement via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations
Requirement: *The Contractor shall submit Care Management Program policies and procedures to LDH for approval within thirty (30) days from DOA/OSP approval of signed contract, and prior to any revisions.* This requirement is partially addressed by the email documents submitted by Magellan titled "UM Policies." Magellan should create a policy or procedure addressing this state contract requirement.
Response
Describe initiatives implemented based on recommendations: The Magellan Health Referral Procedure has been updated to address the state contract requirement via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The complete application through credentialing committee decision shall not exceed sixty (60) calendar days per application.* Magellan provided evidence of the implementation of this requirement through Semi Annual Provider Credentialing and Contracting Reports. This requirement was also addressed in Magellan's Provider Credentialing and Re-credentialing Activities Process Policy and Procedure. However, language meeting this requirement was incorporated into policy in 2022, after the January 1, 2021- December 31, 2021, review period.
Response
Describe initiatives implemented based on recommendations: The Provider Credentialing and Recredentialing procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 2. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations
Requirement: *The Contractor shall not delegate credentialing of providers.* This requirement was addressed in Magellan's Provider Credentialing and Re-credentialing Activities Process Policy and Procedure. However, language meeting this requirement was incorporated into policy in 2022, after the January 1, 2021- December 31, 2021, review period.
Response
Describe initiatives implemented based on recommendations: The Provider Credentialing and Recredentialing procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 3. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Credentialing Application Form and Re-Credentialing Application Form will be submitted to LDH for approval prior to contract implementation and at any time of a requested substantive change in content.* This requirement was addressed in Magellan's Provider Credentialing and Re-credentialing Activities Process Policy and Procedure. However, language meeting this requirement was incorporated into policy in 2022, after the January 1, 2021- December 31, 2021, review period.
Response
Describe initiatives implemented based on recommendations: The Provider Credentialing and Recredentialing procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 2. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.

HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Contractor shall maintain a sufficient number of qualified staff to expeditiously process the credentialing and privileging of qualified service providers.* Though Magellan provided a policy/procedure which, in part, stated that Magellan has mechanisms to review credentialing information for completeness, accuracy, and conflicting information before review by the Credentialing Committee for consideration. This policy/procedure does not specify that Magellan would maintain a sufficient number of qualified staff to expeditiously process the credentialing and privileging of qualified service providers. Language within the Network Practitioner Credentialing and Recredentialing Policy should be included to specify that, Magellan shall maintain a sufficient number of qualified staff to expeditiously process the credentialing and privileging of qualified service providers.
Response
Describe initiatives implemented based on recommendations: The Provider Credentialing and Recredentialing procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 2. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Contractor shall give all network providers and subcontracts access to the Medicaid Behavioral Health Services Provider Manual and the Contractor's Provider Manual, and any updates, either through the Contractor's website, or by providing paper copies to providers who do not have Internet access.* Magellan provided evidence of the implementation of this requirement by providing IPRO with internet web addresses. However, Magellan was unable to fully meet this state contract requirement by failing to provide written policy/procedures effective during the January 1, 2021- December 31, 2021 review period acknowledging this specific state contract requirement. Magellan should include the following state contract requirement into Magellan's Network Practitioner Policy and Standards, "The Contractor shall give all network providers and subcontracts access to the Medicaid Behavioral Health Services Provider Manual and the Contractor's Provider Manual, and any updates, either through the Contractor's website, or by providing paper copies to providers who do not have Internet access."

Response
Describe initiatives implemented based on recommendations: The Provider Communications procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 2. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Contractor shall provide, in accordance with national standards, claims inquiry information to network providers and subcontracts via the Contractor's website.* Magellan provided evidence of the implementation of this requirement by providing IPRO with an internet web address. However, Magellan was unable to fully meet this state contract requirement by failing to provide written policy/procedures effective during the January 1, 2021- December 31, 2021, review period. acknowledging this specific state contract requirement. Magellan should include the following state contract requirement into Magellan's Network Practitioner Policy and Standards, "The Contractor shall provide, in accordance with national standards, claims inquiry information to network providers and subcontracts via the Contractor's website."
Response
Describe initiatives implemented based on recommendations: The Provider Communications procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 3. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations
Requirement: *The Contractor shall develop and maintain methods to communicate policies, procedures, and relevant information to providers through its website, including a Provider Manual developed to disseminate all relevant information to network providers.* Magellan provided evidence of the implementation of this requirement by providing IPRO with an internet web address. However, Magellan was unable to fully meet this state contract requirement by failing to provide written policy/procedures effective during the January 1, 2021- December 31, 2021, review period. acknowledging this specific state contract requirement. Magellan should include the following state contract requirement into Magellan's Network Practitioner Policy and Standards, "The Contractor shall develop and maintain methods to communicate policies, procedures and relevant information to providers through its website, including a Provider Manual developed to disseminate all relevant information to network providers."
Response
Describe initiatives implemented based on recommendations: The Provider Communications procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 3. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Any changes to the member education plan or included materials or activities must be submitted to LDH for approval at least thirty (30) days before the marketing or member education activity, unless the Contractor can demonstrate just cause for an abbreviated time frame.* This requirement is not addressed in the Member Education Plan. Magellan should specify the 30-day time frame in a Member Education Plan. While this requirement is addressed in practice, Magellan should follow the specified recommendation.
Response
Describe initiatives implemented based on recommendations: The Magellan Healthcare Marketing and Education Materials Approval Process has been updated to address the state contract requirement via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified

Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *All marketing activities should provide for equitable distribution of materials without bias toward or against any group.* This requirement is not addressed in the Member Education Plan. Magellan should incorporate the written materials requirements into a policy. While Magellan stated that this requirement was met for the review period, it is unclear if the additional verbiage in the updated Member Education Plan (provided upon follow up) was incorporated during the 2021 review period.
Response
Describe initiatives implemented based on recommendations: The Magellan Healthcare Written Materials Guidelines procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been addressed and updated via page 2. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *All written materials must be clearly legible with a minimum font size of twelve-point, unless otherwise approved by LDH or required by 42 CFR §438.10.* This requirement is not addressed in the Member Education Plan. Magellan should incorporate the written materials requirements into a policy. While Magellan stated that this requirement was met for the review period, it is unclear if the additional verbiage in the updated Member Education Plan (provided upon follow up) was incorporated during the 2021 review period.
Response
Describe initiatives implemented based on recommendations: The Magellan Healthcare Written Materials Guidelines procedure was developed to meet the requirements/recommendations for the request by The State of Louisiana Office of Behavioral Health for the State Fiscal Year of 2022 for the review period of July 1, 2021-June 30, 2022. The requirement has been

addressed and updated via page 2. The policy was approved by LDH-OBH on 8/8/2023 and established as compliant via the current Magellan Draft Compliance Review Report provided to Magellan on 11/29/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The hard copy directory for members shall be updated at least monthly. The web-based online version shall be updated in near real time, however no less than weekly. The electronic version shall be updated prior to each submission to the Medicaid Fiscal Intermediary. While daily updates are preferred, the Contractor shall at a minimum submit no less than weekly.* This requirement is partially addressed by the Network Provider Data Maintenance and Data Integrity policy. Magellan should incorporate this requirement into a provider directory or broader member materials policy. While Magellan met the requirement in practice during the review period, the requirement should be incorporated into a policy.
Response
Describe initiatives implemented based on recommendations: The Magellan Healthcare LA CSoC Provider Directory for Members Policy has been updated to address the state contract requirement via page 2.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The recommendations have been updated via the policy and procedure for implementation of the provision by the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The implementation of the provisions noted in the policy and procedure are monitored and managed in oversight by leadership for the plan.
HSAG Finding
The PIHP submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.