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External Quality Review Annual Technical Report Dental Benefit Program Managers

Louisiana Department of Health

State Fiscal Year 2022

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I. Executive Summary

Purpose of Report

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

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

To comply with *Title 42 CFR Section § 438.364 External review results (a) through (d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Louisiana Department of Health (LDH) contracted with IPRO, an EQRO, to conduct the state fiscal year (SFY) 2021 EQR activities for five MCOs contracted to furnish Medicaid services in the state, as well as two dental benefit program managers (DBPMs) and one PIHP to cover Coordinated System of Care (CSoC) services. During the period under review, SFY 2022 (July 1, 2021–June 30, 2022), LDH's MCOs included Aetna Better Health (ABHLA), AmeriHealth Caritas Louisiana (ACLA), Healthy Blue (HBL), Louisiana Healthcare Connections (LHCC), and UnitedHealthcare Community Plan (UHC). The DBPMs were DentaQuest and MCNA Insurance Company d/b/a MCNA Dental Plans (MCNA). Magellan provided services for the CSoC members.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the four (4) mandatory EQR activities that were conducted. It should be noted that validation of network adequacy and assistance with the quality rating of MCOs were conducted at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. Protocols 1, 2, 3, and 4 require each state to assess their MCOs' information system (IS) capabilities. The regulations at *Title 42 CFR § 438.242* and *457.1233(d)* also require the state to ensure that each MCO maintains a health information system that collects, analyzes, integrates, and reports data for areas including, but not limited to, utilization, grievances and appeals, and disenrollment for reasons other than the loss of Medicaid eligibility. These updated protocols did state that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and

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

4." Both DentaQuest and MCNA underwent an ISCA during fiscal year (FY) 2023. As set forth in *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)*, these activities are:

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

(ii) ***CMS Mandatory Protocol 2:* Validation[4] of Performance Measures –** This activity assesses the accuracy of performance measures (PMs) reported by each MCO and determined the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.

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

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

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

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

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

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2021–2022 EQR activity findings to assess the performance of Louisiana Medicaid MCOs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

The following provides a high-level summary of these findings for the Louisiana Medicaid Managed Care (MMC) Program. The overall findings for DBPMs were also compared and analyzed to develop overarching conclusions and recommendations for each DBPM. These plan-level findings are discussed in each EQR activity section, as well as **Section VIII**.

Strengths Related to Quality, Timeliness and Access

Performance Improvement Projects

Both DBPMs conducted the same PIP, with the goal of increasing utilization of sealants on the first permanent molar by age 10 years.

DentaQuest demonstrated strengths related to **quality** and **access** in their PIP, including:

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

- The DBPM implemented a new intervention to assign members to a dental home, and the corresponding intervention tracking measure (ITM) for the percentage of members who received sealants following dental home assignment showed improvement from 3.6% (2,843/79,733) in the 3rd quarter of 2021 to 13.2% (10,807/81,937) in the 4th quarter of 2021.
- The DBPM implemented a new interactive voice response (IVR) call member education intervention in the 4th quarter of 2021.
- The DBPM implemented a new intervention to provide live telephonic scheduling assistance to parent/guardian in a disparity region in the 4th quarter of 2021.

For MCNA, the barrier analysis included an analysis of disproportionate representation, and findings were used to inform a tailored and targeted intervention with a corresponding ITM.

- Direct member and provider feedback was obtained to inform the barrier analysis.
- Interventions were initiated in May 2021.
- Member interventions were targeted to all enrollees eligible for dental sealants; interventions included both postcards and Care Connections team direct outreach, with corresponding ITMs to facilitate monitoring of progress to meeting all enrollees' oral health needs.
- Provider interventions employed practice pattern analysis by educating providers about their performance relative to their peers.
- The driver diagram demonstrated an understanding and operationalization of the drivers of the PIP aim to improve performance on eligible children's receipt of dental sealants.

Validation of Performance Measures

None identified.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

DentaQuest's overall compliance score was 87.0%, while MCNA demonstrated full compliance in all 10 domains. An overall compliance score of 100% for MCNA indicates that all elements were in full compliance.

Network Adequacy

Both DBPMs demonstrated full compliance with network adequacy standards for open practice main dentists.

Among the dental specialties, the standards were met by both DBPMs for oral surgeons, orthodontists and periodontists within the 60-mile range.

Opportunities Related to Quality, Timeliness and Access

Performance Improvement Projects

DentaQuest

- Indicator 2 (CMS-416 Sealant Measure) did not reach the target rate during the interim period.
- Identification of member and provider barriers and the modification of interventions to address those barriers.
- All tables that report performance indicator and ITM data should indicate the measurement period in the appropriate column headers.

MCNA

- Add an ITM to monitor the provider Clinical Practice Guideline education and care gap report interventions.
- Identify and act upon opportunities to improve identification of alternate member contact information by identifying and reaching out to external collaborators, e.g., PCP office, Healthy Louisiana MCOs.
- Identify barriers to the text messaging intervention and use findings to inform modifications to this intervention.

Performance Measures

Both PM rates for MCNA were below the target set by LDH.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

The following compliance domains were found to be less than fully compliant during the most recent DentaQuest review which took place in July–August 2022: Availability of Services (72.7%), Assurances of Adequate Capacity and Services (86.8%), Coverage and Authorization of Services (96.3%), Provider Selection (98.3%), Enrollee Rights and Protection (74.3%), Grievance and Appeal Systems (84.8%), and Quality Assessment and Performance Improvement (71.6%). It is the expectation of LDH that DentaQuest submits a corrective action plan (CAP) for all elements determined to be less than fully compliant. LDH will officially request a CAP for any item it deems necessary.

Network Adequacy

Neither MCNA nor DentaQuest met the 60-mile access standards for endodontists, periodontists, or prosthodontists.

Conclusion

Findings from SFY 2022 EQR activities highlight the DBPMs' commitment to achieving the goals of the Louisiana Medicaid Quality Strategy. Strengths related to quality of care, timeliness of care, and access to care were observed across all covered populations. In addition, because achieving health equity remains a state priority, it is recognized that opportunities to improve health outcomes exist for both DBPMs.

Recommendations for DBPMs and LDH

For findings and recommendations for DentaQuest compliance elements refer to **Section VIII.** No recommendations were identified for MCNA as all review elements were in full compliance. See **Appendix C** for a full list of Not Met elements for DentaQuest.

II. Louisiana Medicaid Managed Care Program

Managed Care in Louisiana

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

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

Louisiana Medicaid currently serves over 1.8 million enrollees, approximately 35% of the state's population. There are five statewide MCOs: ABHLA, ACLA, HBL, LHCC, and UHC. In February 2020, the state announced its intent to contract with two dental PAHPs for Medicaid following a state bid process that began in June 2019 when LDH issued a request for proposals. LDH selected DentaQuest USA Insurance Company, Inc. and MCNA Insurance Company d/b/a MCNA Dental Plans as its dental partners, effective January 1, 2021. On June 24, 2021, LDH initiated procurement for its full-risk MMC contracts.

Healthy Louisiana covers more than 90% of Louisiana Medicaid members, including nearly 750,000 new members since Medicaid expansion took effect in July 2016. DBPM enrollment as of June 2022 was 1,825,682. **Table 1** shows the Louisiana Medicaid enrollment by DBPM.

Table 1: Current Louisiana Medicaid DBPM Enrollment

DBPM Name	Enrollment as of June 30, 2022	Enrollment as of June 30, 2021
DentaQuest	924,856	871,417
MCNA	900,826	869,080
Total	1,825,682	1,740,497

DBPM: dental benefit program managers; MCNA: MCNA Dental Plans.

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

Louisiana's Medicaid Quality Strategy is based on aims, goals, and objectives to promote improvement in health care delivery and outcomes, along with metrics by which progress can be measured. Louisiana's Quality Strategy is aligned with the Institute of Healthcare Improvement (IHI)'s Triple Aim® and the aims and priorities selected by CMS for their national quality strategy. Posted on the LDH website, Louisiana's 2022 Medicaid Quality Strategy identifies the following three aims:

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

The Louisiana Department of Health 2022 Medicaid Quality Strategy is available for viewing on its website.

Responsibility for Quality Monitoring

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

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

Health Disparities Questionnaire

For this year's technical report, the LA EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, and geography. MCOs were asked to respond to the following question for the period July 1, 2021–June 30, 2022:

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

Full verbatim responses are displayed in **Appendix B**.

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

IPRO's evaluation of LDH's Medicaid Quality Strategy included the physical health, dental, and behavioral health (BH) plans. A summary of IPRO's evaluation methodology is described in **Appendix A**. The strengths, opportunities for improvement and recommendations from IPRO's evaluation for all physical health, dental and BH plans are included here.

Strengths

- Louisiana's *2021 Medicaid Managed Care Quality Strategy*, updated May 2021, is based on aims, goals, and objectives to promote improvement in health care delivery and outcomes, along with metrics by which progress in attaining the goals can be quantitatively measured.
    - Quality metrics used to assess progress in achieving the quality strategy's goals were derived from all five Healthy Louisiana MCOs required to annually report quality PMs including Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics, CMS Adult and Children Core Data Sets, Agency for Healthcare Research and Quality (AHRQ) Preventive Quality Indicators (PQIs), Consumer Assessment of Healthcare Providers and Systems (CAHPS®)consumer satisfaction measures, and several state-specified quality measures. The following strengths are identified by goal:
    - *Ensure access to care to meet enrollee needs:* 4 (33%) of the 12 statewide average (SWA) rates met or exceeded the national Medicaid 50th percentile target objective.
    - *Facilitate patient-centered, whole person care:* All (100%) SWA rates for the three measures for this goal met or exceeded the national Medicaid 50th percentile target objective.

- *Promote wellness and prevention:* 17 (37%) of the SWA rates with benchmarks met or exceeded the national Medicaid 50th percentile target objective, and three SWA rates met the improvement objective.
- *Improve chronic disease management and control:* Two (11%) SWA rates met or exceeded the national Medicaid 50th percentile target objective, and seven (41%) SWA rates for this goal met the improvement objective.
- Overall, there were 26 (32%) SWA rates out of a total of 81 measures with benchmarks that met the target objective, and 11 (14%) SWA rates that met the improvement objective out of a total of 77 rates that could be trended. SWA rates for one of the measures (COPD or Asthma in Older Adults Admission Rate) met both the national target and the improvement objective.

- LDH continues to report on a robust set of monitoring activities including enrollment, network adequacy, quality of care, member satisfaction, program transparency, medical loss ratio, claims, and diabetes and obesity.
- The EQRO monitoring reports included a guide to choosing a health plan; PM results and analysis; two network access and availability provider surveys; and a BH member satisfaction survey. In compliance with federal regulations, the EQRO prepared federally required MCO ATRs. Results for each MCO; a state MCO aggregate; a dental benefit aggregate; and a Magellan CSoC Program report are posted on the LDH website at https://ldh.la.gov/page/4175 .
- A high level of compliance with time and distance standards was reported in the aggregate ATR for all MCOs for primary care providers (PCPs). All five MCOs reported 100% compliance with time and distance access standards to adult PCPs for members in rural areas within 30 miles and 60 minutes. All five MCOs also met 100% compliance with time access standards to pediatric providers and ob/gyn providers for members in rural areas within 60 minutes. Four of the five MCOs met 100% compliance with distance access standards to pediatric PCPs for members in rural areas within 30 miles.
- LDH has shown its commitment to ensuring that improvements in health outcomes lead to equitable improvements in all groups as it continues to integrate procedures for identifying, evaluating, and reducing health disparities throughout the Healthy Louisiana program.
- There is effective communication between the state, MCOs, and the EQRO as evidenced by regularly scheduled meetings and conference calls for EQR activities. LDH commendably communicates with the MCOs, enrollees and the public through a well-designed and informative internet website.
- There is a structured and standardized approach in place for conducting and validating PIPs. Louisiana's statewide collaborative PIP model offers an opportunity for shared learning and an avenue to address the same message to all MMC providers and members. Individual MCO conference calls with the EQRO, quarterly update reports and monthly or quarterly collaborative PIP meetings provide valuable insight on PIP progress, and the use of intervention tracking measures (ITMs) can help quantify opportunities for improvement.
- Healthy Louisiana has successfully integrated quality as a fundamental aspect of the managed care program by introducing an MCO withhold of capitation payment program to improve health outcomes and increase the use of VBP.
- LDH effectively collaborates with other LDH department-wide initiatives for the benefit of Healthy Louisiana members.

Opportunities for Improvement

- Opportunities for improvement are evident for numerous quality metrics identified by the following Quality Strategy goals:
  - *Ensure access to care to meet enrollee needs:* Five of the six SWA rates evaluated for improvement showed a decline in rates between MY 2019 and MY 2020. The SWA rates for all four age groups of the

Adults' Access to Preventive Ambulatory Health Services (AAP) did not meet either the target objective or the improvement objective: AAP: 20–44 years; 45–64 years; 65+ years and total.

- *Improve coordination and transitions of care:* Of the five SWA rates in this measure set, there was no improvement in Plan All-Cause Readmission SWA rates for observed readmissions or for expected readmission rates; and SWA rates for the two Follow-up After Hospitalization for Mental Illness (FUH) measures did not meet either the target or the improvement objective.
- *Facilitate patient-centered, whole person care:* While all of the SWA rates for the three measures in this goal met or exceeded the national Medicaid 50th percentile, none of the measures improved by at least 2.0 percentage points (pps).
- *Promote wellness and prevention:* Opportunities for improvement are evident for the 26 SWA rates in this measure set (57%) that did not meet either the target objective or the improvement objective:
  - PPC: Timeliness of Prenatal Care;
  - Low-Risk Cesarean Delivery;
  - Initiation of Injectable Progesterone for Preterm Birth Prevention;
  - Percentage of Low Birth Weight Births;
  - CIS: DTap; Pneumococcal conjugate; Hepatitis A; Influenza; Combination 4, 6, 7, 8, 9 and 10;
  - FVA: Flu Vaccinations for Adults Ages 18 to 64;
  - WCC: BMI Percentile Total;
  - All six of the CCP: Contraceptive Care – Postpartum measures;
  - CCS: Cervical Cancer Screening; and
  - all three of the Medical Assistance with Smoking and Tobacco Use Cessation measures.
- *Improve chronic disease management and control:* Opportunities for improvement are evident for the nine SWA rates in this measure set (53%) that did not meet either the target objective or the improvement objective:
  - Three PQI rates: Diabetes Short-term Complications; Heart Failure Admission; Asthma in Younger Adults Admissions;
  - CDC: Hemoglobin (HbA1c) Testing; HbA1c Poor Control (> 9.0%); HbA1c Control (< 8.0%);
  - HIV Viral Load Suppression; and
  - ADD: Initiation and Continuation and Maintenance Phases.

- Several core measures listed in the 2021 Quality Strategy were identified as indicators, but MY 2020 data were not collected or available, including several HEDIS measures as well as other measures developed by AHRQ, CMS and the state as listed in Table 3 of the evaluation. Including these measures in the required MY 2021 measure set will provide a more complete evaluation of how well the Healthy Louisiana MMC Program is doing in achieving its quality strategy goals.
- As reported in the *FY 2021 Aggregate Annual Technical Report*, the percent of members in urban areas meeting the time and distance access standards to adult PCPs, pediatric providers and ob/gyns was less than 100% for all five MCOs. Opportunities for improvement for all MCOs are particularly evidenced for access to ob/gyns by distance for members in urban areas and for all but one MCO for access to ob/gyns by distance in rural areas.
- The access and availability provider surveys, conducted by the EQRO, found that overall compliance with timeliness requirements were substantially below the MCO contracted timeliness standards. For ear-nose-throat (ENT) and cardiology specialists, overall compliance with timeliness standards was 36.2% for routine calls and 7.5% for non-urgent calls. For gastroenterologists, urologists and ob/gyns, the overall compliance with timeliness standards was 24.7% for routine calls and 4.6% for non-urgent calls.
- The low overall response rates for the *Healthy Louisiana Behavioral Health Member Satisfaction Survey* conducted by the EQRO resulted in recommendations for the state regarding sampling methodology and survey questions.

Recommendations

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

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

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO. LDH requires MCOs to conduct PIPs, as set forth by *Title 42 CFR § 438.330(d)*. LDH contracted with IPRO to conduct the annual validation of PIPs.

Section 2.11.3 of the contract requires the DBPM to conduct PIPs that focus on dental services, as identified by LDH.

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

- measurement of performance using objective quality indicators;
- implementation of interventions to achieve improvement in access to and quality of care;
- evaluation of the effectiveness of the interventions; and
- planning and initiation of activities for increasing or sustaining improvement.

PIPs engage MCO care and quality managers, providers, and members as a team with the common goal of improving patient care. The MCO begins the PIP process by targeting improvement in annual baseline performance indicator rates and identifying drivers of improved evidence-based performance. The next step is to identify barriers to quality of care and to use barrier analysis findings to inform interventions designed to overcome the barriers to care. Interventions are implemented and monitored on an ongoing basis using quarterly and/or monthly ITMs. Declining or stagnating ITM rates signal the need to modify interventions and re-chart the PIP course. Positive ITM trends are an indication of robust interventions.

The PIP validation procedure builds on the *CMS PIP Validation Protocol* by evaluating quantitative and qualitative data regarding each of the following PIP components:

1. Topic/Rationale
   a. impacts the maximum proportion of members that is feasible;
   b. has potential for meaningful impact on member health, functional status, or satisfaction;
   c. reflects high-volume or high-risk conditions; and
   d. is supported with MCO member data (baseline rates; e.g., disease prevalence).
2. Aims/Goals/Objectives
   a. Aims specify performance indicators for improvement with corresponding goals.
   b. Goals set target improvement rates that are bold, feasible, and based upon baseline data and strength of interventions, with rationales (e.g., benchmarks).
   c. Objectives align aim and goals with interventions.
3. Methodology
   a. Annual PMs are indicated.
   b. Methodology specifies numerator and denominator criteria.
   c. Procedures indicate data source, hybrid versus administrative, and reliability.
   d. Sampling method is explained for each hybrid measure.
4. Barrier analysis, using one or more of the following:
   a. susceptible subpopulations identified using claims data on PMs stratified by demographic and clinical characteristics;
   b. direct member input from focus groups, quality meetings, surveys, and/or care management outreach;

c. direct provider input from focus groups, quality meetings, surveys, and/or care management outreach; and/or
d. QI process data (e.g., fishbone diagram, process flow diagrams).

5. Robust interventions that are measurable using ITMs that
   a. are informed by barrier analysis;
   b. target members, providers, and MCO;
   c. are new or enhanced, starting after baseline year; and
   d. have corresponding monthly or quarterly ITMs to monitor progress of interventions.
6. Results table has
   a. performance indicator rates with numerators and denominators; and
   b. goal rates.
7. Discussion includes an interpretation of extent to which PIP is successful (e.g., compare final to baseline rates, compare final to target rates, interpret ITM rate trends in support of performance indicator improvement).
8. Next steps include
   a. lessons learned;
   b. system-level changes made and/or planned; and
   c. next steps for each intervention.

Technical Methods of Data Collection and Analysis

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

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

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

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

Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. Each evaluation element was scored as Met, Partially Met, Not Met, or Not Applicable, based on the information provided by each MCO. The criteria for each score are presented in **Table 2**.

Table 2: PIP Validation Review Determinations

Determination	Criteria Description
Met	The MCO has demonstrated that it fully addressed the requirement.
Partially Met	The MCO has demonstrated that it fully addressed the requirement, however not in its entirety.
Not Met	The MCO has not addressed the requirement.
Not Applicable	The requirement was not applicable for review.

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

IPRO provided PIP report templates to each MCO for the submission of project proposals, interim updates, and results. All data needed to conduct the validation were obtained through these report submissions.

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

- There were no validation findings which indicate that the credibility of the PIP results is at risk.
- The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution. (Concerns are enumerated.)
- There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk are enumerated.

Description of Data Obtained

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

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

The following PIP was active during the ATR review period (July 1, 2021–June 30, 2022): Increase Utilization of Sealants on First Permanent Molar by the Age of Ten.

The baseline measurement period of the PIP was January 1, 2020, to December 31, 2020, with the intervention period beginning May 3, 2021. The PIP has since been extended to December 31, 2022.

Conclusions and Comparative Findings

IPRO has moderate confidence that the PIP was methodologically sound, produced evidence of significant improvement, and the demonstrated improvement was clearly linked to the QI processes implemented. At this time, since the PIP is in the measurement stage, a determination as to overall improvement cannot be made.

IPRO's detailed PIP validation findings are summarized in **Table 3**–**Table 5**. For each MCO, PIP summaries including aim, interventions, and performance summary are displayed.

Table 3: PIP Validation Results for PIP Elements by DBPM

PIP Validation Element	DentaQuest	MCNA
1. Topic/ Rationale		
a. Impacts the maximum proportion of members that is feasible	M	M
b. Potential for meaningful impact on member health, functional status or satisfaction	M	M
c. Reflects high-volume or high risk-conditions	M	M
d. Supported with MCO member data (baseline rates [e.g., disease prevalence])	M	M
2. Aim		
a. Specifies Performance Indicators for improvement with corresponding goals	M	M
b. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with rationale (e.g., benchmark)	M	M
c. Objectives align aim and goals with interventions	M	M
3. Methodology		
a. Annual Performance Measures indicated	M	M
b. Specifies numerator and denominator criteria	M	M
c. Procedures indicate methods for data collection and analysis	M	M
d. Sampling method explained for each hybrid measure	Not Applicable	Not Applicable
4. Barrier Analysis		
a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M
b. Member feedback	PM	M
c. Provider feedback	PM	M
d. QI Process data ("5 Why's", fishbone diagram)	M	M
5. Robust Interventions that are Measurable using Intervention Tracking Measures		
a. Informed by barrier analysis	PM	M
b. Actions that target member, provider and MCO	PM	M
c. New or enhanced, starting after baseline year	M	PM
d. With corresponding monthly or quarterly intervention tracking (process) measures, (i.e., numerator/denominator; specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	PM
e. One or more member ITMs showed improvement and impact (volume)	PM	PM
f. One or more provider ITMs showed improvement and impact (volume)	NM	NM
6. Results Table (Completed for Baseline, Interim and Final Re-Measurement Years)		
a. Table shows Performance Indicator rates, numerators and denominators	M	M
b. Table shows target rates and rationale (e.g., next highest Quality Compass percentile)	M	M
c. One or more performance Indicators showed improvement	NM	NM

PIP: performance improvement project; DBPM: dental benefits provider manager; MCNA: MCNA Dental Plan; M: Met; NM: Not Met; PM: Partially Met; MCO: managed care organization.

Comments for DentaQuest

4b. Member feedback, IPRO review of interim report 3/7/22: Partially Met. Member feedback on barriers should be obtained in response to stagnating or declining ITMs.

4c. Provider feedback, IPRO review of interim report 3/7/22: Partially Met. Provider feedback on barriers should be obtained in response to stagnating or declining ITMs; however, there were no ITMs to monitor provider interventions, so there was a lack of data to trigger a drill-down barrier analysis.

5a. Interventions informed by barrier analysis, IPRO review of interim report 3/7/22: Partially Met. Region 5 was identified as a disparity subpopulation and, with a 2021 4th quarter ITM rate of 2.9% (20/678), member feedback on barriers is merited to inform modification of the intervention. The American Indian population

was also identified as a disparity subpopulation; however, no tailored and targeted intervention was developed and implemented.

5b. Provider interventions, IPRO review of interim report 3/7/22: Partially Met. The intervention to "Implement provider recall letters" merits explanation of what this intervention entails, as well as a corresponding ITM to document implementation. It is recommended that DentaQuest develop a member gap report for distribution to providers with corresponding education about dental sealants.

5d. ITMs, IPRO review of interim report 3/7/22: Partially Met. There are no ITMs to monitor a provider intervention.

5e. Member ITMs – improvement, IPRO review of interim report 3/7/22: Partially Met. The following ITMs are opportunities for improvement: IVR ITM 1b: Although 41.9% (24,296/57,849) members were contacted via IVR for education, only 2.8% (687/24,296) received a dental sealant. What are the barriers? How will you modify the intervention to address the barriers?

5f. Provider ITMs –improvement, IPRO Review of Interim Report 3/7/22: Not Met. There was no ITM to monitor any provider intervention. See review comments **5b** and **5d**.

6c. Performance indicator improvement, IPRO review of interim report 3/7/22: Not Met. Indicator 2 (CMS-416 Sealant Measure) declined from 14.28% during the baseline period to 13.1% during the interim period.

Comments for MCNA

5c. Interventions modified in response to stagnating/declining ITM rates, IPRO review of interim report 3/31/22: Partially Met. 1) The baseline review comment recommending an ITM to monitor the provider clinical practice guideline (CPG) education and care gap report interventions was not addressed. Consider how to monitor intervention to provide targeted outreach to educate lower performing providers, e.g., percentage of low performing providers who received education and care gap report. 2) In addition, beyond calling at different days/times, there may be an opportunity to improve identification of alternate member contact information by identifying and reaching out to external collaborators, e.g., PCP office, Healthy Louisiana MCOs. 3) Although the text messaging intervention showed success relative to telephonic outreach, the corresponding ITM rate is < 5%. How might you modify this intervention for improvement? 4) The postcard intervention was not initiated as planned on 6/1/21. What is the new planned start date?

5d. ITMs, IPRO review of interim report 3/31/22: Partially Met. See review comment **5c**. Overall, ITM data does not support implementation of robust interventions.

5e. Member ITMs – improvement, IPRO review of interim report 3/31/22: Partially Met.

5f. Provider ITMs –improvement, IPRO review of interim report 3/31/22: Not Met.

6c. Performance indicator improvement, IPRO Review of Interim Report 3/31/22: Not Met.

Table 4 and **Table 5** summarize the PIPs currently being conducted by the dental DBPMs.

Table 4: DentaQuest PIP Summary, 2021–2022

DentaQuest
PIP: Increase Utilization of Sealants on First Permanent Molar by The Age of Ten **Validation Summary:** not available
Aim To increase utilization of sealants on first permanent molar by age 10 years. **Interventions** • Educational IVR calls to head of household on benefits of sealants. • Live call with scheduling assistance to parent/guardian of members aged 6-9 who reside in region 5. • Members assigned to a dental home for routine care. • Partner with LA Seals Smiles to sponsor sealant days at area schools. **Performance Improvement Summary** *Strengths:* • The DBPM implemented a new intervention to assign members to a dental home, and the corresponding ITM for the percentage of members who received sealants following dental home assignment shows improvement from 3.6% (2,843/79,733) in QTR 3 2021 to 13.2% (10,807/81,937) in QTR 4 2021. • The DBPM implemented a new IVR member education intervention in QTR 4 2021. • The DBPM implemented a new intervention to provide live telephonic scheduling assistance to parent/guardian in a disparity region in QTR 4 2021. *Opportunities for Improvement:* • Indicator 2 (CMS-416 Sealant Measure) did not reach the target rate during the interim period. • Identify member and provider barriers and modify interventions to address barriers. • All tables that report performance indicator data and ITM data should indicate the measurement period in the appropriate column headers.

DBPM: dental benefits provider manager; PIP: performance improvement project; DQA: dental quality alliance; CMS: Centers for Medicare and Medicaid Services; ITM: intervention tracking measure; QTR: quarter; IVR: interactive voice response.

Table 5: MCNA PIP Summary, 2021–2022

MCNA
PIP: Increase Utilization of Sealants on First Permanent Molar by The Age of Ten **Validation Summary:** not available
Aims 1. By the end of 2022, MCNA aims to increase the percentage of members receiving at least one sealant on a permanent first molar by the 10th birthdate by four percentage points compared to 2020. 2. By the end of 2022, MCNA aims to increase the percentage of members receiving sealants on all four permanent first molars by the 10th birthdate by four percentage points compared to 2020. **Interventions** 1. Sealant Postcards – Postcard sent to all eligible members during the 48 months prior to their 10th birthdate, who have not received at least one dental sealant on a permanent first molar to provide education on the importance of dental sealants, coverage benefits, and encourage them to schedule an appointment with their dentist. 2. Sealant Text Messages – Monthly text messages to all eligible members who have not received at least one dental sealant on a permanent first molar. Members will be educated on what a dental sealant is and its role in preventing tooth decay. 3. Region 6 Targeted Sealant Outbound Call Campaign – MCNA's Care Connections team will conduct monthly outbound calls to all eligible members during the 48 months prior to their 10th birthdate who reside in Region 6 and have not received at least one dental sealant on a permanent first molar. Members will be provided education

MCNA
PIP: Increase Utilization of Sealants on First Permanent Molar by The Age of Ten **Validation Summary:** not available
on the importance of dental sealants, coverage benefits, and encourage them to schedule an appointment with their dentist. 4. Enhance MCNA's Practice Site Performance Summary (PSPS) Report, which offers providers comparative operational and clinical results for their practice. This quarterly report will be enhanced to include reporting of provider/facility rates for members receiving sealants on permanent first molar teeth by the 10th birthdate. Lower performing providers will receive targeted outreach and education from MCNA's Provider Relations team. **Performance Improvement Summary** *Strengths:* • Member interventions are targeted to all enrollees eligible for dental sealants, include both postcards and Care Connections team direct outreach, with corresponding ITMs to facilitate monitoring of progress to meeting all enrollees oral health needs. • Provider interventions employ practice pattern analysis by educating providers about their performance relative to their peers. • The driver diagram demonstrates an understanding and operationalization of the drivers of the PIP aim to improve performance on eligible children's receipt of dental sealants. *Opportunities for Improvement:* None identified.

MCNA: MCNA Dental Plans; DBPM: dental benefits provider manager; PIP: performance improvement project; ITM: intervention tracking measure.

IV. Validation of Performance Measures

Objectives

LDH selects a set of PMs to evaluate the quality of care delivered by the DBPMs to Louisiana Medicaid members. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) measures assess the effectiveness of state EPSDT programs for Medicaid-eligible individuals under the age of 21 years. These measures examine the number of children and adolescents who received health screenings and preventive health services, were referred for corrective treatment, and who received dental treatment. Individuals enrolled in MMC and FFS programs are included in the EPSDT measures. LDH reports two PMs for the dental program; the CMS-416 and HEDIS Annual Dental Visits (ADV).

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

Technical Methods of Data Collection and Analysis

LDH utilizes a contractor who produces the PMs instead of the DBPMs self-reporting. The contractor produces rates for the CMS-416 measure and HEDIS Annual Dental Visit (ADV) measure.

Description of Data Obtained

IPRO obtained a copy of the HEDIS Annual Dental Visit (ADV) and CMS-416 information from LDH. The HEDIS Annual Dental Visit (ADV) measure was stratified into the following age groups: 2–3 years, 4–6 years, 7–10 years, 11–14 years, 15–18 years, 19–20 years and total. Data was reported for EPSDT measures that assess the total number of children and adolescents receiving dental treatment services: Any Dental Services, Preventive Dental Services, Dental Treatment Services, Sealant on a Permanent Molar, Dental Diagnostic Services, Oral Health Services Provided by a Non-Dentist Provider, and Any Dental or Oral Health Services. The PM reported is for CMS-416 12b, which is for Total Eligibles Receiving Any Dental Services.

Conclusions and Findings

Since the DBPMs did not have an NCQA HEDIS audit performed, there was no final audit report (FAR) issued that detailed the ISCA. IPRO initiated a separate ISCA in June 2022. IPRO found that both MCNA and DentaQuest met the requirement of maintaining a management information system (MIS) that collects, analyzes, integrates and reports data that comply with LDH and federal reporting requirements. The systems provide information on utilization, grievances and appeals. The review comprised the following areas:

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

Table 6 displays measure definitions, steward, reporting period and goals. Both PMs fell below the LDH target for the most recent reporting period.

Table 6: DBPM Performance Measures

Performance Measure	Steward	Reporting Period	Goal	MCNA Rate	DentaQuest Rate
Increase the percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 1–20 years, receiving at least 1 preventative dental service (CMS-416-line 12b)	CMS	Federal Fiscal Year (October 1 – September 31) Reported March 2022	54.50%	27.60%	31.00%
HEDIS Annual Dental Visits (ADV)	NCQA	Measurement year 2021 Reported June 2022	63.75%	49.61%	48.47%

DBPM: dental benefit program manager; MCNA: MCNA Dental Plans; EPSDT: early and periodic screening, diagnostic and treatment; CMS: Centers for Medicare and Medicaid; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance.

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

Objectives

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

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

IPRO conducted compliance audits on behalf of the LDH in 2019, 2020, and 2022. Full compliance audits occur every 3 years, with partial audits occurring within the intervening years. The 2022 annual compliance audit was a full review of each DBPM's compliance with contractual requirements during the period of January 1, 2021, through December 31, 2021.

Technical Methods of Data Collection and Analysis

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

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

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

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

- statement of federal regulation and related federal regulations;
- statement of state regulations;
- statement of state and MCO contract requirement(s);
- suggested evidence;
- reviewer determination;
- prior results;
- descriptive reviewer findings and comments related to findings; and
- MCO response and action plan.

IPRO's compliance audit included a comprehensive evaluation of policies, procedures, files and other materials corresponding to the following 10 domains:

1. Availability of Services
2. Assurances of Adequate Capacity and Services
3. Coverage and Authorization of Services – Utilization Management (UM)
4. Provider Selection
5. Enrollee Rights and Protection
6. Grievance and Appeal Systems
7. Practice Guidelines
8. Health Information Services
9. Quality Assessment and Performance Improvement Program (QAPI)
10. Fraud, Waste and Abuse

During these audits, determinations of "met," "partially met," and "not met" were used for each element under review. A not applicable (N/A) was used if the requirement was not applicable to the DBPM. The definition of each of the review determinations is presented in **Table 7**.

Table 7: Review Determination Definitions

Level of Compliance	Meaning
Met	The DBPM is compliant with the standard.
Partially met	The DBPM is compliant with most of the requirements of the standard but has minor deficiencies.
Not met	The DBPM is not in compliance with the standard.
Not applicable	The requirement was not applicable to the DBPM.

DBPM: dental benefit program manager.

Description of Data Obtained

MCNA and DentaQuest were the two DBPMs in Louisiana during the review period. IPRO conducted compliance reviews on behalf of LDH in 2019, 2020, and in 2022 for MCNA. DentaQuest began providing services to Louisiana members on 1/1/2021. This was DentaQuest's first compliance review as a LA DBPM. Full compliance audits occur every 3 years, with partial audits occurring within the intervening years. A full review of each DBPM's compliance with contractual requirements was conducted for the period of January 1, 2021 through December 31, 2021.

Conclusions and Comparative Findings

Table 8 shows a crosswalk from CFR standards for the compliance review and the compliance audit results. For this audit, compliance determinations of "met," "partially met," "not met," and "not applicable" were used for each element under review.

Table 8: CFR Standards for Compliance Review and DBPM Compliance

CFR Standard Name	CFR Citation	DentaQuest	MCNA
Availability of Services	438.206	72.7%	100.0%
Assurances of Adequate Capacity and Services	438.207	86.8%	100.0%
Coverage and Authorization of Services – UM	438.210	96.3%	100.0%
Provider Selection	438.214	98.3%	100.0%
Enrollee Rights and Protection	438.224	74.3%	100.0%
Grievance and Appeal Systems	438.228	84.8%	100.0%
Practice Guidelines	438.236	100.0%	100.0%

CFR Standard Name	CFR Citation	DentaQuest	MCNA
Health Information Systems	438.242	100.0%	100.0%
Quality Assessment and Performance Improvement	438.330	71.6%	100.0%
Fraud, Waste and Abuse	438.608	100.0%	100.0%
Total		**87.0%**	100.0%

CFR: Code of Federal Regulations; DBPM: dental benefit program manager; MCNA: MCNA Dental Plans; UM: utilization management.

DentaQuest demonstrated full compliance in 3 of the 10 domains: Practice Guidelines, Health Information Services and Fraud, Waste and Abuse . In total, 557 elements were reviewed for compliance. Of the 557 elements, 415 were determined to fully meet the regulations, while 84 partially met the regulations, 26 did not meet the regulations, and 32 were determined to be not applicable. The overall compliance score was 87.0% (**Table 9**). For a complete list of Not Met elements see **Appendix C**.

Table 9: DentaQuest's Audit Results by Compliance Audit Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	% Full[1]
Availability of Services	24	10	12	0	2	72.7%
Assurances of Adequate Capacity and Services	57	48	3	6	0	86.8%
Coordination and Continuity of Care						
Coverage and Authorization of Services-UM	80	74	6	0	0	96.3%
Provider Selection	30	29	1	0	0	98.3%
Enrollee Rights and Protection	77	39	35	2	1	74.3%
Grievance and Appeal Systems	70	57	3	9	1	84.8%
Subcontractual Relationships						
Practice Guidelines	9	9	0	0	0	100.0%
Health Information Services	8	8	0	0	0	100.0%
QAPI	101	41	24	9	27	71.6%
Fraud Waste and Abuse	101	100	0	0	1	100.0%
Total	**557**	**415**	**84**	**26**	**32**	**87.0%**

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

MCNA demonstrated full compliance in 10 of the 10 domains (**Table 10**). 557 elements were reviewed for compliance. Of the 557, 524 all were determined to fully meet the regulations and 33 were not applicable. The overall compliance score for MCNA was 100.0% (**Table 10**).

Table 10: MCNA's Audit Results by Compliance Audit Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	% Full[1]
Availability of Services	24	22	0	0	2	100%
Assurances of Adequate Capacity and Services	57	57	0	0	0	100%
Coordination and Continuity of Care						
Coverage and Authorization of Services-UM	80	79	0	0	1	100%
Provider Selection	30	30	0	0	0	100%
Enrollee Rights and Protection	77	76	0	0	1	100%
Grievance and Appeal Systems	70	69	0	0	1	100%

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	% Full[1]
Subcontractual Relationships						
Practice Guidelines	9	9	0	0	0	100%
Health Information Services	8	8	0	0	0	100%
QAPI	101	74	0	0	27	100%
Fraud Waste and Abuse	101	100	0	0	1	100%
Total	**557**	**524**	**0**	**0**	**33**	**100.0%**

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

VI. Validation of Network Adequacy

General Provider Network Access Requirements

In the absence of a CMS protocol for *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, IPRO assessed MCO compliance with the standards of *Title 42 CFR § 438.358 Network adequacy standards* and 2.6 of the state's Medicaid Services Contract.

Per the contract, the contractor shall ensure that members have access to providers within reasonable time (or distance) parameters. The MCOs are required to maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered the contract for all members, including those with limited English proficiency or physical or mental disabilities.

Objectives

Louisiana DBPMs are required to meet standards set by LDH to ensure that members have access to providers within reasonable time (or distance) parameters. The DBPMs are required to maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered the contract for all members, including those with limited English proficiency or physical or mental disabilities.

DBPMs must ensure that a sufficient number of primary and specialty care providers are available to members to allow for a reasonable choice among providers. This is required by federal Medicaid requirements, state licensure requirements, NCQA accreditation standards, and the state's Medicaid Managed Care Services Contract.

Dental Access to Care and Network Availability Standards

Network Capacity and Geographic Access Standards

- The primary dental provider (PDP) may practice in a solo or group practice or may practice in a clinic (i.e., federally qualified health center [FQHC], rural health clinic [RHC] or outpatient clinic). The DBPM shall contract with a sufficient number of PDPs needed to meet the geographic access, appointment, and wait time standards outlined in the contract.
- The DBPM shall provide access to dentists that offer extended office hours (before 8:00 a.m., after 4:30 p.m., and/or on Saturdays) at least 1 day per week.
- Network providers must offer office hours at least equal to those offered by commercial dental insurance plans.
- If an enrollee requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM network who accepts new patients, it shall not be considered a violation of the access requirements for the DBPM to grant the enrollee's request. The DBPM shall not submit encounters for travel outside of the access standards if an appropriate provider was available within the access standards.
- The DBPM shall comply with the following maximum distance requirements, as determined by mapping software (e.g., MapQuest™, Google Maps™, ArcGIS®). Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.

Distance to Primary Dental Services

- Travel distance from enrollee's place of residence shall not exceed 30 miles or 60 minutes one-way for rural areas and 10 miles or 20 minutes for urban areas.

Distance to Specialty Dental Services

- Travel distance shall not exceed 60 miles one-way from the enrollee's place of residence for at least 75% of enrollees.
  - The DBPM shall ensure, at a minimum, the availability of the following specialists and other providers for enrollees under the age of 21 years:
    - Endodontists;
    - Maxillofacial surgeons;
    - Oral surgeons;
    - Orthodontists;
    - Pedodontists;
    - Periodontists;
    - Prosthodontists; and
    - Special needs pedodontists.

Timely Access Standards

- Urgent care services – within 24 hours of a request for services that do not require prior authorization and within 48 hours for a request for services that do require prior authorization;
- Primary dental care – within 30 days; and
- Follow-up dental services – within 30 days after assessment.

Technical Methods of Data Collection and Analysis

IPRO's evaluation was performed using the MCOs' quarterly GeoAccess reports, which document the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in the *Provider Network Companion Guide*. IPRO compared each MCO's calculated distance analysis by specialty and by region to the LDH standards and a determination of whether the standard was met or not met was made.

Table 11 displays the LDH-established access, distance, and time standards that were applicable in calendar year 2021 for dental providers.

Table 11: Louisiana Network Access Standards

Access Requirements
Distance requirements for primary dental services
Rural: Within 30 miles or sixty minutes
Urban: Within 10 miles or twenty minutes
Distance requirements for specialty dental providers
Within sixty miles
(75) percent of enrollees and shall not exceed ninety (90) miles one-way

Description of Data Obtained

The DBPM monitors its provider network for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes. Each DBPM is required to submit monthly reports to LDH. IPRO received these reports from LDH.

Conclusions and Comparative Findings

Table 12 shows provider network accessibility by DBPM. Green cells indicate that the DBPM met the benchmark for that region and standard, while red cells indicate that it did not. It can be seen that the DBPMs met both the 10-mile and 30-mile benchmarks of 95% for open practice main dentists (**Table 12**).

Among dental specialties, both DentaQuest and MCNA met the benchmarks for oral surgeons and orthodontists (**Table 12**). For MCNA, the remaining specialties did not meet the standard. For DentaQuest, the remaining specialties did not meet the distance (60 miles) standard.

It should be noted that general dentists provide specialty services, as it is within their scope of practice.

In addition, during the 2022 compliance review, both DBPMs demonstrated that they ensure that specialty care is provided to members as needed throughout the state.

Table 12: GeoAccess Provider Network Accessibility

Specialty[1]	Region	Standard	DentaQuest	MCNA
Open practice main dentist	Urban	1 in 10 miles	99.6%	96.5%
	Rural	1 in 30 miles	100%	99.4%
Endodontist	All	1 in 60 miles	83.6%	68.5%
	All	1 in 90 miles	95.9%	86.9%
Oral surgeon	All	1 in 60 miles	99.8%	94.9%
	All	1 in 90 miles	99.3%	99.7%
Orthodontist	All	1 in 60 miles	98.8%	98.0%
	All	1 in 90 miles	99.9%	99.9%
Periodontist	All	1 in 60 miles	73.6%	60.8%
	All	1 in 90 miles	93.7%	66.9%
Prosthodontist	All	1 in 60 miles	87.8%	55.2%
	All	1 in 90 miles	97.1%	66.0%

[1] Benchmark is 95% for open practice main dentists and 90% for all specialties.
MCNA: MCNA Dental Plans; red: did not meet the benchmark; green: met or exceeded the benchmark.

VII. EQRO's Assessment of MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 13** and **Table 14** display the DBPM's responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

DBPM Responses to Previous EQR Recommendations

Table 13 displays MCNA's progress related to the *State of Louisiana Department of Health Aetna Better Health of Louisiana Annual External Quality Review Technical Report FINAL REPORT April 2021,* as well as IPRO's assessment of MCNA's response.

Table 13: MCNA Response to Previous EQR Recommendations

Recommendation for MCNA	MCNA Response/Actions Taken	IPRO Assessment of DBPM Response[1]
Compliance with Medicaid and CHIP Managed Care Regulations MCNA should address the two domains that were found partially met. Adequate Capacity and Service ▯ Recommendation: MCNA should continue to enroll providers to expand provider coverage to meet the time and distance requirements. ▯ Recommendation: MCNA should continue to enroll providers to expand provider coverage to meet the	MCNA's recruitment efforts for General Dentists and Specialists is on-going. The Network Development team updates the list of non-contracted providers in the State of Louisiana on an annual basis. MCNA uses listings from the Louisiana State Board of Dentistry; NPI Registry; and the internet to identify if any new providers have moved in to the state of Louisiana, specifically in identified areas where MCNA is deficient in meeting the time and distance requirements. MCNA also works closely with the Louisiana State University School of Dentistry to identify any newly graduate students that may be interested in participating in the LA Medicaid network. MCNA's Network Development team will reach out to all non-contracted providers to recruit and contract providers that may be interested in participating in MCNA's Medicaid network. There are currently, however, parishes in the state of Louisiana that do not have any specialists available to contract and therefore will not have the ability to improve in these areas. Please note however, that we monitor utilization care for specialty services to ensure our members are accessing the care that is needed and many times, this is accomplished from care received by general dentists as it is within their scope of their license to provide specialty care as needed. In areas where gaps are identified and in the event that members will need specialty care, MCNA's Provider Relations team and the Case Management team will work together to identify non-participating providers that will be willing to treat members on a case by case basis. This presents an opportunity to contract with these providers for participation in the network. Needless to say, the Network Development team will continue to update our non-contracted listing and will continue to reach out to these providers for contracting opportunities throughout the year in an effort to enroll additional providers in areas where time and distance requirements are not met. QAPI:	Addressed

Recommendation for MCNA	MCNA Response/Actions Taken	IPRO Assessment of DBPM Response[1]
time and distance requirements. QAPI Recommendation: MCNA should include in its policy that it has a member advocate on its QI Committee. This recommendation was made during the 2019 compliance review. Subsequently, MCNA has updated their policy to include the member advocated on the member committee.	This recommendation was addressed and policy 2.103LA QI Program Description has been updated to include the Member Advocate Outreach Specialist Manager as a member of the Quality Improvement Committee (QIC). Policy 2.103LA page 8	
Performance Measures MCNA should determine interventions and steps to increase their performance measure rates.	MCNA will continue to update our provider listings by searching for new providers that have been identified in the LA State Board of Dentistry, NPI Registry and the internet to identify contracting opportunities. MCNA's Network Development team will recruit and identify opportunities for contracting by continuing to reach out to providers that have not joined MCNA's Medicaid network on an on-going basis. In areas where there is a shortage of Specialists in many parishes, MCNA ensures that members are receiving specialty care from general dentists in the area as providing specialty services by general dentists is within their scope of their license. MCNA is planning to meet with the Louisiana State University School of Dentistry in the first quarter of 2023 to identify opportunities to meet with dental students that plan to graduate in 2023 to discuss opportunities in participating in Medicaid networks. QAPI: MCNA's HEDIS ADV and preventive services rate for CY/FFY 2020 did not meet the mandated goals as the COVID-19 pandemic directly impacted the utilization of services. During the measurement year, provider offices experienced closures, limited staff and providers were mandated by the state to only render emergency/urgent care. MCNA's current utilization rates are in line with the most recent study released by CMS wherein preliminary data show the rate of dental services for children during the Public Health Emergency (PHE) period continuing to remain slightly below averages from the pre-PHE period by as much as 20% per month. Subsequently, to encourage members to return to the dental office and ease their fears, MCNA mailed postcards to all members letting them know our dentists are following the ADA and CDC guidelines to help keep them "safe" in addition to following enhanced infection control procedures, which has led to less than one percent of COVID-19 infections among dentists. MCNA also implemented a preventive	Partially Addressed

Recommendation for MCNA	MCNA Response/Actions Taken	IPRO Assessment of DBPM Response[1]
	outbound call campaign, a monthly sealant postcard mailing, and we are in the process of enhancing our Practice Site Performance Summary (PSPS) report to showcase provider's sealant and fluoride utilization in comparison to that of their peers. MCNA closely monitors the outcomes of its interventions on a monthly basis via an intervention dashboard in PowerBI. In turn, the intervention outcomes are reported quarterly to the Quality Improvement Committee (QIC) for discussion and possible modification. This has led to an increase in MCNA's ADV and preventive services rate as of 2022 by at least three percentage points.	
Network Adequacy MCNA should continue to enroll providers to expand provider coverage to meet the time and distance requirements.	MCNA's Network Development team will continue to identify opportunities to enroll providers to expand provider coverage to meet the time and distance requirements using interventions identified above.	Partially Addressed

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

MCNA: MCNA Dental Plans; EQR: external quality review; DBPM: dental benefit program manager; PIP: performance improvement project; ITM: intervention tracking measure.

Table 14: DentaQuest Response to Previous EQR Recommendations

Recommendation for DentaQuest	DentaQuest Response/Actions Taken	IPRO Assessment of DBPM Response[1]
Network Adequacy DentaQuest should contract with additional oral surgeons and orthodontists, where available.	DentaQuest Provider Recruitment – Enhance Oral Surgeons and Orthodontic Participation DentaQuest's recruitment efforts occur continuously throughout the year. We are now using the Public Provider Master File from LDH as a source of prospects including oral surgeons and orthodontists. We use this tool as the baseline for ongoing recruitment efforts. We also obtain a listing of all licensed dentists, specialists and hygienists in the State of Louisiana, and adjacent counties in Arkansas and Mississippi. We will compare both the Provider Master File and licensed dental provider listing to our network data file to identify all Medicaid providers, non-Medicaid providers, and key dental health stakeholders (including but not limited to: Federally Qualified Health Centers (FQHC), Community Health Centers (CHCs), Dental Universities, key large group dental offices and Indian Health Centers (IHCPS)). We use the results of the comparison to identify non-DentaQuest providers to target during the recruitment phase of our network development efforts. We have	Partially Addressed

Recommendation for DentaQuest	DentaQuest Response/Actions Taken	IPRO Assessment of DBPM Response[1]
	implemented this strategy to add additional Oral Surgeons and Orthodontists to our network in all parishes in Louisiana. Network staff follows up via telephone with all targeted list practitioners to confirm receipt of the information packet, answer any questions related to the program, and solicit each practitioner's participation in the program. All currently credentialed Medicaid providers will be welcomed into the network with a completed DentaQuest Provider Agreement. Network staff also works very closely with the DentaQuest Dental Advisory Committee (DAC) to obtain a better understanding of the needs of the current dental network. Recruitment goals will be established for the network size, taking into consideration the targeted number of practitioners, access needs of enrollees, Dental Home access, contractual requirements with LDH, as well as program costs. In addition to these sources, we also work with peer/peer referrals, associations, key stakeholders and the MCO plans to identify oral surgeons and other dental specialty providers in their network. To the extent MCO plans contract with providers we do not contract with, we will target our provider network recruitment efforts toward those providers. We believe there is a high likelihood they will be willing to contract with DentaQuest since they already participate in Medicaid.	

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

MCNA: MCNA Dental Plans; EQR: external quality review; DBPM: dental benefit program manager; PIP: performance improvement project; ITM: intervention tracking measure.

VIII. MCO Strengths, Opportunities for Improvement, and EQR Recommendations

Title 42 CFR §438.364(a)(4) states that EQR technical reports must include an assessment of strengths and weaknesses, as well as recommendations for each managed care entity. **Table 15** and **Table 16** highlight each DBPM's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of SFY 2021 EQR activities as they relate to **quality**, **timeliness** and **access**.

Table 15: MCNA Strengths, Opportunities and EQR Recommendations

EQR Activity		Quality	Timeliness	Access
Strengths				
PIPs	• Member interventions are targeted to all enrollees eligible for dental sealants, include both postcards and Care Connections team direct outreach, with corresponding ITMs to facilitate monitoring of progress to meeting all enrollees oral health needs. • Provider interventions employ practice pattern analysis by educating providers about their performance relative to their peers. • The driver diagram demonstrates an understanding and operationalization of the drivers of the PIP aim to improve performance on eligible children's receipt of dental sealants.	**X**	--	--
Performance Measures	None identified.	--	--	--
Compliance with Medicaid and CHIP Managed Care Regulations	A review of MCNA demonstrated full compliance in all 10 domains with an overall compliance score of 100%.	**X**	**X**	**X**
Network Adequacy	Both DBPMs demonstrated full compliance with network adequacy standards for open practice main dentists. Among the dental specialties, the standards were met by both DBPMs for oral surgeons, orthodontists and periodontists within the 60-mile range.	--	**X**	**X**
Opportunities for improvement				
PIPs	There may be an opportunity to improve identification of alternate member contact information by identifying and reaching out to external collaborators, e.g., PCP office, Healthy Louisiana MCOs.	**X**	--	--
Performance Measures	Both performance measure rates were below the target goals.	**X**	**X**	**X**
Compliance with Medicaid and CHIP Managed Care Regulations	None identified.	--	--	--
Network Adequacy	MCNA did not meet the 60-mile access standards for endodontists, periodontists, or prosthodontists.	--	--	**X**

EQR Activity		Quality	Timeliness	Access
Recommendations to MCNA to address quality, timeliness and access				
PIPs	It is recommended that MCNA develop a member gap report for distribution to providers with corresponding education about dental sealants.	--	X	X
Performance Measures	MCNA should determine interventions and steps to increase their performance measure rates.	X	X	X
Compliance with Medicaid and CHIP Managed Care Regulations	None identified.	--	--	--
Network Adequacy	MCNA should continue to enroll providers to expand provider coverage to meet the distance requirements.	--	--	X

MCNA: MCNA Dental Plans; EQR: external quality review; PIP: performance improvement project; ITM: intervention tracking measure; CHIP: Children's Health Insurance Program; PCP: primary care provider; MCO: managed care organization.

Table 16: DentaQuest Strengths, Opportunities and EQR Recommendations

EQR Activity		Quality	Timeliness	Access
Strengths				
PIPs	• Interventions with corresponding ITMs are indicated for individual member outreach and community outreach. • A more resource intensive intervention is planned to conduct live calls to susceptible subpopulations (to be identified). • As a new plan, to address the lack of historical data for the DQA performance indicator, DentaQuest has provided an interim substitute measure (i.e., CMS-416 data). • The DBPM described a process for ongoing analysis of ITMs for continuous quality improvement.	X	--	--
Performance Measures	N/A—New plan, was not required to submit PMs.	--	--	--
Compliance with Medicaid and CHIP Managed Care Regulations	A full compliance review for DentaQuest demonstrated compliance in 3 of the 10 domains: Practice Guidelines, Health Information Services, and Fraud, Waste and Abuse. DentaQuest's overall compliance score was 87.0%.	X	X	X
Network Adequacy	DentaQuest demonstrated full compliance with network adequacy standards for open practice main dentists. DentaQuest demonstrated compliance with network adequacy standards for oral surgeons and orthodontists within the 60-mile range, and demonstrated partial compliance with network adequacy standards for endodontists, periodontists and prosthodontists (standard was met for the 90-mile range but not the 60-mile range).	--	--	X

EQR Activity		Quality	Timeliness	Access
Opportunities for Improvement				
PIPs	There is an opportunity to address the decline in Indicator 2 (CMS-416 Sealant Measure) by identifying member and provider barriers and modifying interventions to address barriers.	**X**	--	--
Performance Measures	NA—New plan, was not required to submit PMs.	--	--	--
Compliance with Medicaid and CHIP Managed Care Regulations	The following compliance domains were found to be less than fully compliant during the most recent DentaQuest review which took place in July-August 2022. Availability of Services (72.7%), Assurances of Adequate Capacity and Services (86.8%), Coverage and Authorization of Services (96.3%), Provider Selection (98.3%), Enrollee Rights and Protection (74.3%), Grievance and Appeal Systems (84.8%), and Quality Assessment and Performance Improvement (71.6%).	**X**	**X**	--
Network Adequacy	DentaQuest did not meet the 60-mile standard for endodontists, periodontists and prosthodontists.	--	--	**X**
Recommendations to DentaQuest to address quality, timeliness and access				
PIPs	None identified.	--	--	--
Performance Measures	N/A—New plan, was not required to submit PMs.	--	--	--
Compliance with Medicaid and CHIP Managed Care Regulations	• DentaQuest should include the required language for all policies identified within the DBPM's 2022 Healthy Louisiana EQRO Compliance Audit. • DentaQuest should develop processes to monitor and reduce the no-show rate for primary care dentists and incorporate them into a policy. • DentaQuest should incorporate the member rights and responsibilities into its own section in the handbook, as well as into a policy. • DentaQuest should develop policies to identify and assess the quality and appropriateness of care furnished to Louisiana Medicaid enrollees with special health care needs. • Develop and implement a QAPI program and a corresponding description document that is exclusive to Louisiana Medicaid enrollees. • DentaQuest should develop and implement a QAPI evaluation program and corresponding document that is exclusive to Louisiana Medicaid enrollees. • DentaQuest's QAPI governing body should be separate from Utilization Management and be exclusive to Louisiana Medicaid enrollees. • DentaQuest's QAPI committee should be exclusive to Louisiana Medicaid enrollees and meetings should be held quarterly. • DentaQuest's QAPI committee should be exclusive to Louisiana Medicaid enrollees and include a member advocate representative. • DentaQuest should conduct individual primary care dentist and primary care dentist practice quality performance measure profiling and report summary findings in a Program Evaluation document.	**X**	**X**	**X**

EQR Activity		Quality	Timeliness	Access
Network Adequacy	DentaQuest should contract with additional endodontists, periodontists and prosthodontists, where available.	--	--	**X**

EQR: external quality review; PIP: performance improvement project; ITM: intervention tracking measure; DQA: dental quality alliance; CMS: Centers for Medicare and Medicaid Services; DBPM: dental benefit program manager; N/A: not applicable; PM: performance measure; CHIP: Children's Health Insurance Program; EQRO: external quality review organization; QAPI: quality assessment and performance improvement.

IX. Appendix A

IPRO's Assessment of the Louisiana Medicaid Quality Strategy

Evaluation Methodology

To evaluate Louisiana's *2021 Medicaid Managed Care Quality Strategy*, a review of federal regulations was initially conducted to clearly define the requirements of the quality strategy and guide the evaluation methodology.

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

Second, IPRO evaluated Louisiana Medicaid's quality monitoring activities. This evaluation consisted of a review of LDH monitoring reports regarding enrollment, network adequacy, quality dashboard, program transparency, medical loss ratio (MLR) and diabetes and obesity reviews. LDH's approach to addressing health disparities and the use of sanctions were also reviewed. Further evaluation of the quality strategy consisted of a review of external quality review (EQR) report documents, including a guide to choosing a Medicaid plan, performance measure (PM) results, annual EQR technical reports, access and availability survey findings and a BH member satisfaction survey.

Third, IPRO evaluated state-MCO-EQRO communications by reviewing online data sources. In addition to the LDH and EQR monitoring reports, other website examples of data transparency such as MCO executed contracts, Medical Care Advisory Committee meeting reports and informational bulletins were reviewed.

Fourth, IPRO evaluated Louisiana Medicaid's strategies and interventions to promote quality improvement by reviewing MCO performance improvement project (PIP) reports, MCO withhold of capitation payments to increase the use of value-based payment (VBP) and improve health outcomes, and the *Louisiana Health Information Technology Roadmap*. Other LDH department-wide quality initiatives, such as Taking Aim at Cancer in Louisiana, Louisiana Perinatal Quality Collaborative, Opioid Strategy and Hepatitis C Elimination Strategy were also reviewed.

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

X. Appendix B

MCO Verbatim Responses to IPRO's Health Disparities Questionnaire

For this year's ATR, the LA EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, and geography. MCOs were asked to respond to the following questions for the period July 1, 2021–June 30, 2022:

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

[Responses and formatting below were taken directly from the DBPM submissions]

MCNA Response

As part of MCNA's Louisiana community outreach and education plan, our Member Advocate Outreach Specialists (MAOS) create collaborative relationships with various community organizations in order to educate and advocate for MCNA's Louisiana Dental Medicaid Members. MCNA's MAOS focus outreach efforts to organizations that serve typically underserved areas and individuals (individuals with special needs, rural areas, and tribal organizations). MCNA Dental works with these organizations to educate members about proper oral health as well as benefits they have through the Medicaid program. MCNA Dental also works with these community partners to assist uninsured people with locating resources from medical to dental to financial.
Corporate level activities to date include:

- Providing a MAOS dedicated solely to the Louisiana Medicaid Dental Program
- Providing sponsorship for member and provider events
- Enhancing cultural competency training and resources

At the local level, MCNA Dental has:

- Worked with various school districts to help ensure children have needed back to school supplies by participating in back to school events
- Attended meetings with various health care management organizations to help plan community events to provide dental education to the public
- Participated in health fairs and other community events
- Set up tables at several health district WIC clinics to provide information regarding the importance of proper oral hygiene during pregnancy and for babies
- Set up tables at various thrift stores to provide dental education to the public

To remove language barriers for our diverse population and meet the cultural needs of our members, MCNA deployed text messages that were delivered to members in their primary language for the top five languages spoken including English, Spanish, French, Vietnamese, and Arabic.
○ For the time period of July 1, 2021 through June 30, 2022, MCNA deployed 181,972 preventive text messages, (one per household) advising the parent/guardian to schedule an appointment for preventive dental care.
 Of the 181,972 members who received a text, 48,800 (27%) members visited their primary care dentist within 60 days post receipt of a text message and of those members, 39,271 (80%) received a preventive service.

MCNA continued its sealant campaign, "Sealants & Smiles" which offers providers an additional $10 fee per first permanent molar for children ages 6-9. MCNA also continued its Elite Provider Program, which encourages and incentivizes primary dental providers to enhance their population's oral health management capabilities and focus. Providers who consistently demonstrate high approval rates for prior authorizations and claims are rewarded with

a reduced level of administrative oversight of their practices and other perks highly valued by the provider community.

Lastly, 1,632 Practice Site Performance Summary (PSPS) reports were distributed to provider offices. This tool is designed to assist providers in understanding how their clinical and operational performance compares with that of their peers. A preventive services section of the report includes the percent of assigned children receiving a preventive visit in accordance with the American Association of Pediatric Dentistry's Periodicity Schedule. Each provider receives a detailed quarterly report that outlines individual provider performance with respect to claims, prior authorizations, and preventive services in comparison to goals and peer groupings.

DentaQuest Response

From July 1, 2021, to June 30 2022, DentaQuest continued to collect enrollment and dental utilization data, as wells as publicly reported performance metrics, to design and implement interventions to address health disparities in the Louisiana Medicaid population. As previously reported, oral health literacy in the Medicaid population is low, thereby affecting utilization of dental services and ultimately impact health outcomes. To improve oral health literacy, DentaQuest has created and implemented a number of educational materials, oral health education opportunities, as well as incentives, to educate enrollees on the importance of oral health and, most importantly, arm them with the skills and knowledge to effectively manage their oral health.

All members receive a welcome call and a health risk assessment within 30 days of enrollment. During this welcome call, enrollees are educated on their dental benefit, the importance of routine dental care and they are provided with contact information should they need any additional support. The secondary component of the welcome call is the health risk assessment (HRA). The HRA consists of a series of questions that identify areas where the member may be at risk and require more individual support. Responses indicating enrollee has poor oral health, dental pain, chronic medical conditions or need assistance with transportation, housing, food and/or utilities indicate the enrollee may be at risk. Once it has been identified that an enrollee may be at risk, an outreach call is placed by a Care Coordinator who conducts a more comprehensive assessment to determine the level of support the enrollee needs. Based on the results of this assessment, enrollees are placed into care coordination or case management. Enrollees who require short term support to improve their functional capability and minimize barriers to care receive care coordination. Those members who require long term support are enrolled in the Case Management program. Case Management provides high risk enrollees with long term additional supports to promote enrollee self-management, treatment adherence and improved oral health. In the time period mentioned above, we were able to identify and provide assistance to more than 682 enrollees who were experiencing difficulties accessing dental care due to physical, intellectual, or behavioral conditions, as well as Social Determinants of Health such as lack of transportation and food and housing insecurity.

For the adult population receiving extractions, there is a potential risk for opioid usage. According to research, opioid analgesics are among the most frequently prescribed drugs by dentist. To help members understand the risk and provide information on effective non-opioid options, an online tool with risk assessment is available to these enrollees. With the understanding that many enrollees may not initially recognize the value in this education, an incentive is provided. Enrollees who complete this program receive a Walmart gift card. Qualifying enrollees can access pain medication safety information and as well as apply for the incentive directly from the Member Section of the DentaQuest website.

To help combat dental caries and align with the national average for sealants, an incentive program called Healthy Behaviors was developed. In the Healthy Behaviors program, children receive an oral health kit when

they have their adult molars sealed. In addition to this program, DentaQuest conducted an analysis of disproportionate utilization to better understand the sealant usage for children who turned 10 years of age during the measurement year. This analysis stratified the data by race and geography and will be used to develop targeted interventions to educate enrollees on sealants and improve percentage of sealants on a permanent tooth. During the first half of 2022, we started a systematic outreach campaign targeting the households of children 6-9 years old who were no compliant for sealants during the measurement year. A combination of robocall, live call, and mailer campaigns was used to provide education on the importance of preventive dental care, specifically sealants, and encourage these enrollees to schedule a dental appointment with their dentist. More than 20,600 enrollees were successfully contacted using this strategy. Of particular interest were those enrollees residing in Region 5, a historically underserved area of the state. With the use of a live call campaign, we are able to successfully contact more 58% of targeted enrollees, approximately 1464 individuals. The same strategy was repeated for the second half of 2022. Using this analysis to focus on specific populations and areas, we hope to decrease existing oral health disparities and improve outcomes.

Medicaid enrollees are at higher risk for developing Early Childhood Caries (ECC), a severe form of caries (cavities), that affects the primary teeth of infants, toddlers, and preschool children. ECC can progress rapidly and, if left untreated, may result in pain and infection. The Healthy Beginnings program promotes prevention and early detection of ECC by educating parents/caregivers on oral health, routine dental visits and proper dental care for infants and children. Parents/caregivers of enrollees ages 0-2 will receive a birthday card at birth and first and second birthday with age-appropriate dental care instructions, tips on preventing ECC, and information on how to locate a provider.

As we gather information on enrollees DentaQuest will continue to assess the membership for opportunities to improve oral health literacy, encourage routine dental care and improve sealant use. Through analysis we will proactively identify the oral health disparities that exist in this population and develop strategies to ensure enrollees are receiving the education, tools and knowledge to understand the importance of prevention, access quality dental care and improve oral health literacy. Cumulatively these actions will reduce the existing disparities and improve health outcomes.

XI. Appendix C

DentaQuest Not Met Compliance Review Elements

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
2.6.7.1.1	Any change that would cause more than five percent (5%) of members to change the location where services are received or rendered.	Not Met	This requirement is not addressed in any policy or procedure.	Network will update our policy accordingly.	No change to determination. DentaQuest agrees with finding.
2.6.7.1.3	A loss of any participating specialist which may impair or deny the members' adequate access to providers;	Not Met	This requirement is not addressed in any policy or procedure.	Network will update our policy accordingly.	No change to determination. DentaQuest agrees with finding.
2.6.7.1.4	Other adverse changes to the composition of the DBPM which impair or deny the members' adequate access to providers.	Not Met	This requirement is not addressed in the Provider Network Adequacy policy.	Network will update our policy accordingly.	No change to determination. DentaQuest agrees with finding.
2.6.7.3	When the DBPM has advance knowledge that a material change will occur, the DBPM must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Not Met	This requirement is not addressed in any policy or procedure.	Network will update our policy accordingly.	No change to determination. DentaQuest agrees with finding.
2.6.7.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	Not Met	This requirement is not addressed in any policy or procedure.	Network will update our policy accordingly.	No change to determination. DentaQuest agrees with finding.

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
2.6.9.8	Significant Traditional Providers. The DBPM shall make a good faith effort to include in its network, primary care dentists and specialists who are significant traditional providers (STPs) provided that the STP: agrees to participate as an in-network provider and abide by the provisions of the provider contract; and meets the credentialing requirements. The list of STPs will be available on the LDH web site.	Not Met	This requirement is not addressed in any policy or procedure.	Network will update our policy accordingly.	No change to determination. DentaQuest agrees with finding.
2.3.13.1	LDH's FI shall send the DBPM a daily file in the format specified in the DBPM Systems Companion Guide. The file shall contain the names, addresses and phone numbers of all newly eligible members, as determined by the DBPM. The DBPM shall use the Member File to assign primary care dentists and to identify and initiate communication with new members via welcome packet mailings as prescribed in this RFP.	Not Met	This requirement is not addressed by the Member Handbook or Welcome Letter. (The enrollment policy furnished was approved in March 2022.)	DQ will incorporate this requirement into a policy going forward for 2022.	No change to determination. DentaQuest agrees with finding.

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
2.9.10	The DBPM must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for DBPM performance. The DBPM must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.	Not Met	This requirement is not addressed in the customer service or phone lines policies.	Workforce Management continually runs forecasting tasks to ensure the appropriate amount of staff is allocated as needed. Staffing schedules are adjusted to accommodate any shifts in volumes.	No change to determination.
2.10.1.5	The DBPM shall refer all DBPM members who are dissatisfied with the DBPM or its subcontractor in any respect to the DBPM's designee authorized to review and respond to grievances and appeals and require corrective action.	Not met	This requirement is not addressed in the Member Appeals or Grievances policies.	CGA06-INS-Member Complaints and Grievances-Primary Delegation. Page 6. 4	The submitted documentation is dated from 2022. This documentation does not apply to this review period of CY 2021, therefore no change in determination.

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2.10.6.11	The DBPM shall not create barriers to timely due process. The DBPM shall be subject to sanctions if it is determined by DHH that the DBPM has created barriers to timely due process, and/or, if ten (10) percent or higher of grievance decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to: labeling complaints as inquiries and funneled into an informal review; failing to inform members of their due process rights; failing to log and process grievances and appeals; failure to issue a proper notice including vague or illegible notices; failure to inform of continuation of benefits; and failure to inform of right to State Fair Hearing.	Not met	This requirement is not addressed in the Member Appeals or Grievances policies.	CGA01-INS-MCD-Member Appeals-Medicaid Page 13. 4	The submitted documentation is dated from 2022. This documentation does not apply to this review period of CY 2021, therefore no change in determination.
2.10.3.1.2	The DBPM will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail).	Not Met	This requirement is not addressed in any of the policies or procedures. DentaQuest stated they will speak with LDH about this requirement since CMS had removed this requirement.	CGA01-INS-MCD-Member Appeals-Medicaid Page 12. A. e) i.	The submitted documentation is dated from 2022. This documentation does not apply to this review period of CY 2021, therefore no change in determination.

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
2.5.8.5.1.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except when the period of advanced notice is shortened to five days if probable member fraud has been verified by the date of the action.	Not Met	This requirement is not addressed in any policy or procedure, including the Notice of Action policy.	These requirements will be added within the UM08-INS-Authorization Review policy in the Louisiana Medicaid Exhibit.	No change to determination. DentaQuest agrees with finding.
2.5.7.2.1	The DBPM shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of	Not Met	This requirement is not addressed in any policy or procedure, including the Notice of Action policy.	These requirements will be added within the UM08-INS-Authorization Review policy in the Louisiana Medicaid Exhibit.	No change to determination. DentaQuest agrees with finding.
2.5.7.3	If the DBPM extends the timeframe for a service authorization decision, it shall:	Not Met	This requirement is not addressed in any policy or procedure, including the Notice of Action policy.	These requirements will be added within the UM08-INS-Authorization Review policy in the Louisiana Medicaid Exhibit.	No change to determination. DentaQuest agrees with finding.
2.5.8.3.4	For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.	Not Met	This requirement is not addressed in any policy or procedure,	These requirements will be added within the UM08-INS-Authorization Review policy in	No change to determination. DentaQuest agrees with finding.

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
			including the Notice of Action policy.	the Louisiana Medicaid Exhibit.	
2.5.7.2.3	For expedited service authorization decisions where a provider indicates, or the DBPM determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.	Not Met	This requirement is not addressed in any policy or procedure, including the Notice of Action policy.	These requirements will be added within the UM08-INS-Authorization Review policy in the Louisiana Medicaid Exhibit.	No change to determination. DentaQuest agrees with finding.
2.5.7.2.2	The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the DBPM justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Not Met	This requirement is not addressed in any policy or procedure, including the Notice of Action policy.	These requirements will be added within the UM08-INS-Authorization Review policy in the Louisiana Medicaid Exhibit.	No change to determination. DentaQuest agrees with finding.
2.11.2.1.3	The DBPM is encouraged to include a member advocate representative on the QAPI Committee.	Not Met	This requirement is not addressed. DentaQuest states that they do not have a member	DentaQuest has drafted the 2023 version of our QAPI workplan specific to Louisiana	No change to determination. DentaQuest agrees with finding.

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
			advocate representative at this time.	Medicaid enrollees that will go into effect upon approval. The workplan details the quarterly and annual activities planned by the QAPI committee.	
2.11.2.4	Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management activities; and	Not Met	This requirement is not addressed in the National Quality Improvement Program Evaluation 2021 documented cited by DentaQuest because this document references TennCare on page 18 and Florida Healthy Kids on page 20, but there is no mention of Louisiana Medicaid enrollees.	DentaQuest has drafted the 2023 version of our QAPI workplan specific to Louisiana Medicaid enrollees that will go into effect upon approval. The workplan details the quarterly and annual activities planned by the QAPI committee.	No change to determination.

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2.11.2.2.11	Ensure that a QAPI committee designee attends DHH Quality Committee meetings.	Not Met	This requirement is not met.	Incorporating LA into existing meeting but LA Reps were represented in 2021 on the meeting	No change to determination.
2.11.2.3.1	The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the DBPM and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, shall:	Not Met	This requirement is not met in the Quality Improvement Workplan 2022 because this document does not specifically address activities planned and in progress for Louisiana Medicaid enrollees and was not effective during the review period.	DentaQuest has drafted the 2023 version of our QAPI workplan specific to Louisiana Medicaid enrollees that will go into effect upon approval. The workplan details the quarterly and annual activities planned by the QAPI committee.	No change to determination.
2.11.2.3.1.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	Not Met	This requirement is not met in the Quality Improvement Workplan 2022 because this document does not specifically address activities planned	DentaQuest has drafted the 2023 version of our QAPI workplan specific to Louisiana Medicaid enrollees that will go into effect upon approval. The	No change to determination.

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
			and in progress for Louisiana Medicaid enrollees and was not effective during the review period.	workplan details the quarterly and annual activities planned by the QAPI committee.	
2.11.2.3.1.3	Include a description of the DBPM staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and	Not Met	This requirement is not addressed.	DentaQuest has drafted the 2023 version of our QAPI workplan specific to Louisiana Medicaid enrollees that will go into effect upon approval. The workplan details the quarterly and annual activities planned by the QAPI committee.	No change to determination.
2.11.2.4	The DBPM shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities; Recommended new and/or improved QI activities; and Evaluation of the impact and effectiveness of the QAPI program. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the DBPM of additional required reports no less than sixty (60) days prior to due date of those reports.	Not Met	This requirement is not addressed in the National Quality Improvement Program Evaluation 2021 documented cited by DentaQuest because this document references	DentaQuest has drafted the 2023 version of our QAPI workplan specific to Louisiana Medicaid enrollees that will go into effect upon approval. The workplan details the quarterly and	No change to determination.

LA Citation	State Contract Requirements	Review Determination	Comments	MCO Comments	Final Recommendations
			TennCare on page 18 and Florida Healthy Kids on page 20, but there is no mention of Louisiana Medicaid enrollees.	annual activities planned by the QAPI committee.	
6.3.5.3	The DBPM shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.	Not Met	This requirement is not addressed in the Development and Execution of Compliance CAP policy.	CE/ Compliance	No change to determination.
	Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the DBPM shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH.	Not Met	This requirement is not addressed in the Development and Execution of Compliance CAP policy.	CE/ Compliance	No change to determination. DentaQuest agrees with finding.