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

External Quality Review Technical Report

for

AmeriHealth Caritas Louisiana

February 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

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

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 18, 2024.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 18, 2024.

who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2024 (July 1, 2023–June 30, 2024) are displayed in Table 1-1. Of note, no MCEs are exempt from EQR.

Table 1-1—Louisiana's Medicaid MCEs

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

Scope of External Quality Review

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

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

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

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

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

Report Purpose

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

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

Definitions

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

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

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

Methodologies

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

Aggregating and Analyzing Statewide Data

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

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

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

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

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

Louisiana's Medicaid Managed Care Quality Strategy

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

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

Goals and Objectives

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

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

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

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

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

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

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

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

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

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

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

[1-4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Dec 16, 2024.

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

Recommendations

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

monetary penalty. This assessment should identify root causes for noncompliance and then work to identify appropriate interventions to eliminate noncompliance and improve performance.

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

Actions on External Quality Review Recommendations

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

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

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

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

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

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for AmeriHealth Caritas Louisiana (ACLA) conducted with Louisiana Medicaid managed care throughout SFY 2024.

Validation of Performance Improvement Projects

With the start of HSAG's EQRO contract with LDH in March 2023, HSAG initiated PIP validation training and technical assistance activities to assist LDH, ACLA, and other MCOs in transitioning to HSAG's PIP validation process and methodology. ACLA actively worked on PIPs throughout SFY 2024, and PIP validation activities were initiated. LDH required ACLA to conduct PIPs on the following state-mandated topics during SFY 2024:

- *Behavioral Health Transitions of Care*
- *Ensuring Access to the COVID-19 [coronavirus disease 2019] Vaccine Among Healthy Louisiana Enrollees*
- *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*
- *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*
- *Screening for HIV [human immunodeficiency virus] Infection*
- *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*

At the time this report was drafted, HSAG's first validation cycle of ACLA's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP was in progress and is scheduled to be completed in SFY 2025; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations for this PIP will be reported in next year's annual EQR technical report.

Validation of Performance Measures

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

Information Systems Capabilities Assessment

Based on a review of the final audit reports (FARs) issued by ACLA's certified HEDIS compliance auditor, HSAG found that ACLA fully met the standard for all four of the applicable NCQA HEDIS information systems (IS) standards.

HEDIS—Quality, Timeliness, and Access

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2023 NCQA national 50th percentile, which served as the benchmark. A total of 47 measures, comprising 290 measure indicators, were selected for analysis. Of the 290 measure indicators, 12 were not reported in Quality Compass and were therefore excluded from comparisons to NCQA national 50th percentile benchmarks.

Of the 278 HEDIS measures/measure indicators with an associated benchmark, ACLA had 173 indicators that performed greater than the NCQA national 50th percentile benchmark, 94 indicators that performed lower than the NCQA national 50th percentile benchmark, and 11 indicators that were not compared to the NCQA national 50th percentile benchmark because the reported rates were *Not Applicable (NA)* (i.e., small denominator) or *NB* (i.e., no benefit). Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

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

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

Validation of Network Adequacy

Provider Directory Validation

HSAG's provider directory validation (PDV) indicated that, overall, the provider information maintained and provided by ACLA was poor, which impacted access to care due to the inability of members to find a provider that delivered the requested services. Table 1-4 provides a summary of the findings from the study.

Table 1-4—Summary of PDV Findings

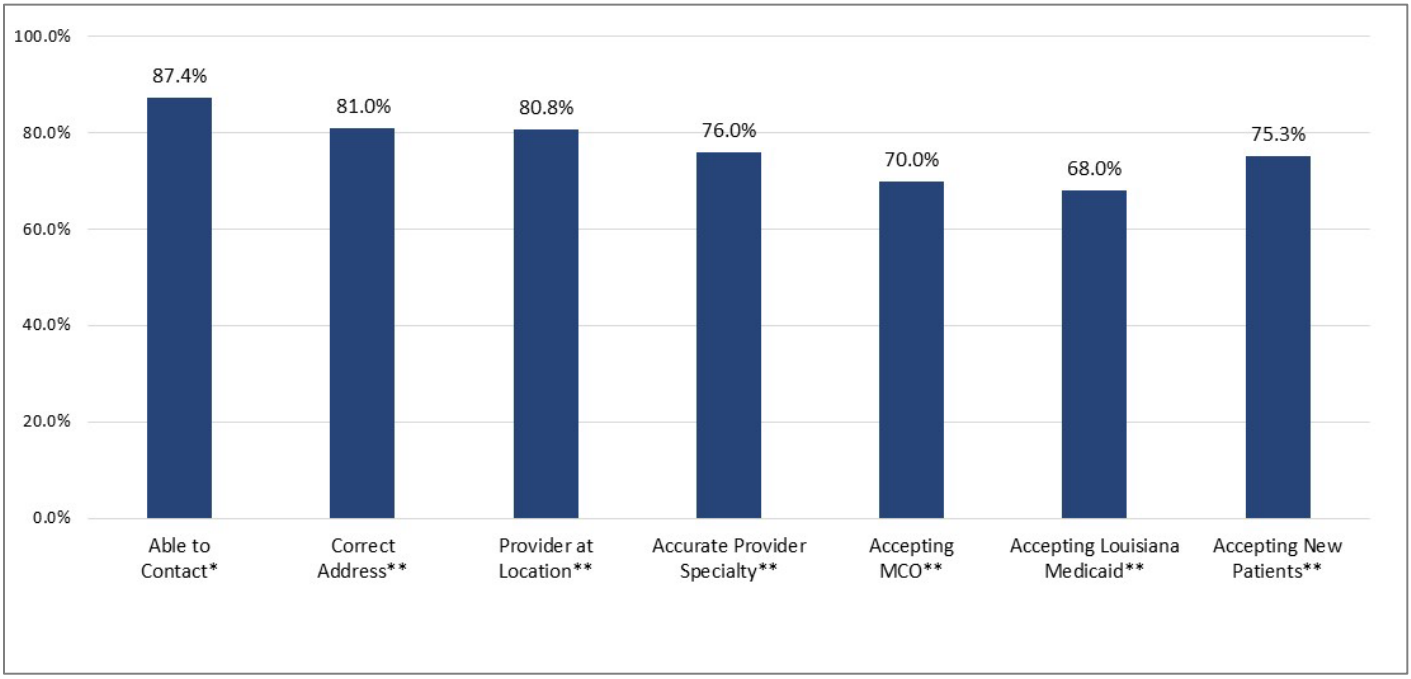
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 68.0 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 70.0 percent of providers accepted the requested MCO.

Concerns	Findings
Overall acceptance of new patients was low.	Overall, 75.3 percent of providers accepted new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews.
Provider's specialty in the provider directory was incorrect.	Overall, 76.0 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Affiliation with the sampled provider was low.	Overall, 80.8 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 81.0 percent of respondents reported that ACLA's provider directory reflected the correct address.

While the overall PDV response rate was relatively high at 87.4 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of the Louisiana Medicaid acceptance, ACLA acceptance, and new patient acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate at or below 81.0 percent.

Figure 1-1 presents the summary results for all sampled ACLA providers.

Figure 1-1—Summary Results for All Sampled ACLA Providers



*The denominator includes all sampled providers.
**The denominator includes cases reached.

ACLA's weighted PDV compliance scores by specialty type ranged from 40.7 percent (internal medicine/family medicine) to 64.0 percent (OB/GYN).

Provider Access Survey

HSAG's provider access survey indicated that, overall, the provider information maintained and provided by ACLA was poor. Table 1-5 provides a summary of the findings from the study.

Table 1-5—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 45.7 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 52.1 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of Louisiana Medicaid was low.	Overall, 58.6 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 60.0 percent of providers accepted the requested MCO.
Provider's specialty in the provider data was inaccurate.	Overall, 72.1 percent of providers confirmed the specialty listed in the provider data was accurate.
Address information was inaccurate.	Overall, 87.9 percent of locations confirmed the address listed in the provider data was accurate.

Table 1-6 presents the provider access survey call outcomes.

Table 1-6—Provider Access Survey Call Outcomes

Specialty	Able to Contact[1]	Correct Address[2]	Offering Services[2]	Accepting MCO[2]	Accepting Medicaid[2]	Accepting New Patients[2]	Confirmed Provider[2]
Total	**73.3%**	**87.9%**	**72.1%**	**60.0%**	**58.6%**	**52.1%**	**45.7%**
Primary Care	61.7%	83.8%	73.0%	56.8%	51.4%	45.9%	35.1%
Pediatrics	62.5%	88.0%	72.0%	68.0%	68.0%	60.0%	56.0%
Obstetricians/ Gynecologists (OB/GYNs)	85.0%	88.2%	76.5%	64.7%	64.7%	58.8%	52.9%
Endocrinologists	78.9%	86.7%	73.3%	60.0%	60.0%	60.0%	60.0%
Dermatologists	100.0%	91.7%	83.3%	66.7%	66.7%	58.3%	58.3%
Neurologists	90.0%	88.9%	61.1%	50.0%	50.0%	44.4%	33.3%
Orthopedic Surgeons	80.0%	93.8%	68.8%	56.3%	56.3%	43.8%	37.5%

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.

ACLA's weighted provider access survey compliance scores by specialty type ranged from 29.4 percent (primary care) to 61.1 percent (dermatologists). ACLA's after-hours weighted provider access survey compliance scores by specialty type ranged from 6.7 percent (primary care) to 80.0 percent (neurologists).

NAV Audit

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

Table 1-7 contains the provider types, at the statewide level, by urbanicity, for which ACLA achieved the 100 percent threshold for 100 percent of members to have access.

Table 1-7—ACLA Distance Requirements Met by 100 Percent of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity
Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine and Physician Extenders)	Rural
Pharmacy	Rural
Cardiology	Rural
Gastroenterology	Rural
Neurology (Adult)	Rural
Ophthalmology	Rural
Orthopedics (Adult)	Urban
	Rural
Behavioral Health Specialist (Other Specialty Care: Advanced Practice Registered Nurse [APRN-BH] specialty, Licensed Psychologist or Licensed Clinical Social Worker [LCSW])	Rural
Psychiatric Residential Treatment Facilities (PRTFs), PRTF (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	Urban
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Rural

HSAG assessed ACLA's results for statewide provider-to-member ratios by provider type and determined that ACLA's statewide results met or exceeded LDH-established requirements.

HSAG assessed ACLA's results for behavioral health providers to determine the accessibility and availability of appointments and determined that ACLA met all LDH-established performance goals for three reported appointment access standards, as displayed in Table 1-8.

Table 1-8—ACLA Appointment Access Standards Compliance Rate for Behavioral Health

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	98.8%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	98.8%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	98.8%

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared ACLA's 2024 achievement scores to its corresponding 2023 achievement scores and the 2024 NCQA national averages to determine whether there were statistically significant differences. Overall, ACLA's 2024 adult and general child achievement scores were not statistically significantly higher than in 2023 nor statistically significantly higher than the 2024 NCQA national averages on any of the measures. ACLA's 2024 adult achievement score was statistically significantly lower than in 2023 for *Rating of All Health Care*.

Behavioral Health Member Satisfaction Survey

HSAG compared ACLA's 2024 achievement scores to the 2024 Healthy Louisiana statewide average (SWA) and 2023 scores to determine whether there were statistically significant differences. Overall, ACLA's 2024 child achievement score was statistically significantly lower than the 2023 score for *Help to Manage Condition*. Additionally, ACLA's 2024 adult score was statistically significantly higher than the 2023 score for *Help Finding Counseling or Treatment*.

Health Disparities Focus Study

While the 2023 Annual Health Disparities Focus Study included MCO-specific findings, the overall results and conclusions of this study are not MCO-specific. Therefore, please refer to the annual MCO aggregate technical report for high-level statewide findings from the 2023 Annual Health Disparities Focus Study.

Case Management Performance Evaluation

During SFY 2024, HSAG conducted two CMPE reviews. HSAG evaluated the MCOs' compliance with the case management provisions of their contracts with LDH, including the rates of engagement in case management; the specific services offered to enrollees receiving case management; and the effectiveness of case management in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

The reviews identified successes and opportunities for improvement, which were used by LDH to inform guidance and develop CAPs to address performance. The following strengths were identified for ACLA:

- The results of both reviews demonstrated that no findings resulted in concerns regarding an enrollee's health, safety, or welfare.
- The results of both reviews demonstrated that the health plan was successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans, and multidisciplinary care team (MCT) development.

ACLA demonstrated opportunity for improvement with elements related to ongoing scheduled case management activities. Specific findings and recommended actions were provided to ACLA through HSAG's CAP process. ACLA successfully completed remediation actions to address the CAP findings, and the CAP was closed in October 2024.

Quality Rating System

Figure 1-2 displays the 2024 Health Plan Report Card, which presents the 2024 rating results for each MCO. The 2024 Health Plan Report Card shows that, for the Overall Rating, ACLA received 3.5 stars. ACLA received 3.0 stars for the Prevention and Equity composite, including 5.0 stars and 4.0 stars for the Equity and Other Preventive Services subcomposites, respectively, demonstrating strength for ACLA in these areas. However, ACLA received 2.0 stars for the Women's Reproductive Health and Reduce Low Value Care subcomposites, and 1.0 star for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for improvement for ACLA in these areas.

Figure 1-2—2024 Health Plan Report Card

Issued 08/2024

Healthy Louisiana

2024 HEALTH PLAN REPORT CARD

The ratings below compare the performance of Louisiana's Medicaid health plans. This report card shows the results of care in the areas of Consumer Satisfaction, Prevention and Equity, and Treatment, and can aid you and your family when deciding on a health plan.

PERFORMANCE KEY	Lowest	Low	Average	High	Highest	Insufficient Data
	★	★★	★★★	★★★★	★★★★★	—

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Overall Rating*	★★★½	★★★½	★★★½	**New	★★★½	★★★½
CONSUMER SATISFACTION						
Overall Consumer Satisfaction	★★★½	★★★½	★★★★	**New	★★★★	★★★★★
Getting care: How easily and quickly did members get appointments, preventive care, tests, and treatments?	★★★★½	★★½	★★★½	**New	★★★½	—
Satisfaction with plan physicians: How happy are members with their primary care doctors?	★★★½	★★★½	★★★★½	**New	★★★★★	★★★★★
Satisfaction with plan services: How happy are members with their health plan and their overall care?	★★½	★★★½	★★★★½	**New	★★★★	★★★★★
PREVENTION AND EQUITY						
Overall Prevention and Equity	★★½	★★★	★★★	**New	★★½	★★★
Children/adolescent well-care: Do children and adolescents receive vaccines and weight assessments?	★★	★★½	★★½	**New	★★	★★½
Women's reproductive health: Do women receive care before and after their babies are born?	★★½	★★	★★★	**New	★★½	★★★½

Continued on next page...

Figure 1-2—2024 Health Plan Report Card (cont.)

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Cancer screening: Do female members receive cervical cancer screenings?	★★	★★★	★★	**New	★★★	★★★
Equity: Do health plans collect race and ethnicity information from their members?	★★★★★	★★★★★	★★★★★	**New	NC	★★★★★
Other preventive services: Do members receive important preventive services?	★★★½	★★★★	★★★★	**New	★★★½	★★★
TREATMENT						
Overall Treatment	★★★	★★★	★★★	**New	★★★	★★★
Respiratory: Do people with respiratory issues get the services/treatments they need?	★★★½	★★★	★★★½	**New	★★★	★½
Diabetes: Do people with diabetes get the services/ treatments they need?	★★★½	★★★½	★★★★	**New	★★★★	★★★★½
Heart disease: Do people with heart disease get the services/ treatments they need?	★★★½	★★★	★★½	**New	★★★½	★★★
Behavioral health—care coordination: Do people with behavioral health issues get the follow-up care they need?	★½	★	★½	**New	★	★½
Behavioral health—medication adherence: Do people with behavioral health issues stay on prescribed medications?	★★★½	★★½	★★½	**New	★★★½	★★
Behavioral health—access, monitoring, and safety: Do people on behavioral health medications receive the services/ monitoring they need?	★★★★	★★★½	★★★★	**New	★★★	★★★★
Risk-adjusted utilization: Do members who are discharged from the hospital have unplanned readmissions within 30 days?	★★★	★★★	★★★	**New	★★★	★★★
Reduce low value care: Do members with low back pain receive unnecessary imaging tests?	★★	★★	★★	**New	★★	★★

**This rating includes all measures in the report card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*

***Due to Humana Healthy Horizons being a new plan in 2023, data are not available yet. Humana Healthy Horizons will be included in future health plan report cards.*

Insufficient Data indicates that the plan was missing the majority of data for the composite.

NC indicates that the plan received a rating of 0 for the measure in this composite.

This report card is reflective of data collected between January 2023 and December 2023.

The categories and measures included in this report card are based on the 2024 National Committee for Quality Assurance (NCQA) Health Plan Ratings and LDH required measures lists. When feasible, categories and measures were kept consistent with the prior year's health plan report card, but some measures and categories were removed due to data availability. Any analysis, interpretation, and conclusions based on the data is solely that of the author. Anyone desiring to use or reproduce the materials must obtain approval from LDH.

2. Validation of Performance Improvement Projects

Results

SFY 2024 (review period) was the second year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs, including ACLA, to carry out PIPs to address five state-mandated topics that were validated during SFY 2024. LDH also required the MCOs to initiate a new PIP topic, *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*, in January 2024 to be validated during SFY 2025. Table 2-1 summarizes the PIP topics carried out by ACLA in SFY 2024.

Table 2-1—SFY 2024 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Behavioral Health Transitions of Care	• 6 years and older • 13 years and older
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• 5–11 years • 12–15 years • 16 years and older
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• 6 months–18 months • 19 months–2 years • 3–5 years
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• 21–64 years
Screening for HIV Infection	• 13 years and older • 15–65 years
*Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees**	• *Not applicable*

*PIP to be validated during SFY 2025.

For each PIP topic, ACLA collaborated on improvement strategies, meeting at least monthly with LDH and other MCOs, throughout the year. ACLA also submitted updates on improvement strategies and interim indicator results for each PIP topic quarterly that were reviewed by HSAG and LDH. HSAG provided feedback and technical assistance on PIPs to LDH and ACLA at group and one-on-one meetings throughout the contract year.

Table 2-2 summarizes key PIP validation milestones that occurred from July 2023 through June 2024, the end of SFY 2024.

Table 2-2—SFY 2024 MCO PIP Activities

PIP Activities and Milestones	Dates
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	July 2023–June 2024
The MCOs submitted Quarter 2 2023 PIP updates	July 2023
HSAG provided initial PIP proposal validation findings to the MCOs	September 2023
The MCOs submitted Quarter 3 2023 PIP updates	October 2023
The MCOs submitted draft PIP reports, to HSAG for validation	January 2024
The MCOs submitted Quarter 1 2024 PIP updates	April 2024
HSAG provided draft PIP report validation findings to the MCOs	February 2024
The MCOs submitted final PIP reports to HSAG for validation	March 2024
HSAG provided final PIP validation reports to the MCOs	April 2024

In SFY 2025, ACLA will submit draft PIP reports for initial validation in January 2025 and the final PIP reports for final validation in March 2025. HSAG will complete the second annual validation cycle in April 2025.

Validation Results and Confidence Ratings

Table 2-3 summarizes ACLA's final PIP validation results and confidence ratings delivered by HSAG in April 2024.

Table 2-3—SFY 2024 PIP Validation Results for ACLA

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Transitions of Care	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		

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

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

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

Performance Indicator Results

Table 2-4 displays data for ACLA's *Behavioral Health Transitions of Care* PIP.

Table 2-4—Performance Indicator Results for the *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 715 D: 4,053	17.64%	N: 741 D: 3,790	19.55%▲			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 1,389 D: 4,053	34.27%	N: 1,408 D: 3,790	37.15%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 159 D: 722	22.02%	N: 117 D: 565	20.71%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 243 D: 722	33.66%	N: 179 D: 565	31.68%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 252 D: 1,469	17.15%	N: 141 D: 1,158	12.18%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 424 D: 1,469	28.86%	N: 230 D: 1,158	19.86%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-5 displays data for ACLA's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-5—Performance Indicator Results for the *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 76,027 D: 160,161	47.47%	N: 56,953 D: 119,679	47.59%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 65,993 D: 160,161	41.20%	N: 49,441 D: 119,679	41.31%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 21,267 D: 54,589	38.96%	N: 15,395 D: 39,733	38.75%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 37,155 D: 71,215	52.17%	N: 28,631 D: 54,276	52.75% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 4,451 D: 10,834	41.08%	N: 4,770 D: 11,411	41.80%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 13,154 D: 23,523	55.92%	N: 8,157 D: 14,529	56.14%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 18,476 D: 54,589	33.85%	N: 13,341 D: 39,733	33.58%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 31,971 D: 71,215	44.89%	N: 24,758 D: 54,276	45.62% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 3,723 D: 10,834	34.36%	N: 3,979 D: 11,411	34.87%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 11,823 D: 23,523	50.26%	N: 7,363 D: 14,259	51.64% ▲	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 6,451 D: 21,037	30.67%	N: 4,751 D: 17,409	27.29%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 5,257 D: 21,037	24.99%	N: 3,784 D: 17,409	21.74%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 4,955 D: 34,900	14.20%	N: 3,758 D: 30,844	12.18%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 3,659 D: 34,900	10.48%	N: 2,763 D: 30,844	8.96%	*Not Assessed*

N–Numerator D–Denominator
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-6 displays data for ACLA's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-6—Performance Indicator Results for the *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 295 D: 5,651	5.22%	N: 281 D: 3,315	8.48%▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 585 D: 5,670	10.32%	N: 683 D: 5,965	11.45%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 622 D: 11,073	5.62%	N: 520 D: 9,007	5.77%			*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 1,502 D: 22,358	6.72%	N: 1,484 D: 18,287	8.12%▲			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-7 displays data for ACLA's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-7—Performance Indicator Results for the *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 18,158 D: 36,891	49.22%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-8 displays data for ACLA's *Screening for HIV Infection* PIP.

Table 2-8—Performance Indicator Results for the *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 3,496 D: 5,038	69.39%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 2,405 D: 6,628	36.29%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 3,568 D: 5,624	63.44%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 9,916 D: 110,751	8.95%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Interventions

Table 2-9 summarizes ACLA's final CY 2023 barriers and interventions.

Table 2-9—Barriers and Interventions Reported by PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Lack of hospital participation in health information exchange • Provider difficulty in identifying patients needing follow-up care • Lack of member access to care	• Utilization of admission, discharge, and transfer (ADT) notification report of inpatient admits from *Follow-Up After Hospitalization for Mental Illness* population. • Utilization of ADT notification report of emergency department (ED) admits or discharges from the *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and*

PIP Topic	Barriers	Interventions
		Other Drug Abuse or Dependence populations. • Utilization of ADT notification report to determine case management notification of ED admits or discharges from the *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* populations.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Challenges with reaching a large volume of eligible members via case management outreach alone	• Case managers telephonically outreach to enrollees enrolled in case management to assist with scheduling vaccine appointment. • Care coordinator and community navigator telephonically outreach enrollees not enrolled in case management to assist with scheduling vaccine appointment.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of access to a dental provider • Lack of provider knowledge that fluoride varnish applications can be done in a PCP office	• Enhanced enrollee outreach and education. • Enrollee outreach to facilitate dental appointment scheduling. • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) enrollee outreach and education to establish a dental home and facilitate dental provider appointment scheduling. • Outreach to enrollees in rural areas to provide education and care coordination.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee knowledge of multiple health conditions and importance of obtaining screening • Providers do not consistently recommend screening for enrollees	• Enhanced case management outreach to assist enrollees with scheduling cervical cancer screening. • Outreach and education to provider offices on the availability of gaps in care reports and enrollee and provider incentives, and to assist

PIP Topic	Barriers	Interventions
		with any other barriers reported by the provider offices • Quarter 4 provider push with Quarter 4 provider incentive offered outside of Quality Enhancement Program, incentive outreach and education.
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Enhanced case management outreach for HIV screening for enrollees with current/past injection drug use. • Enhanced case management outreach for HIV screening for enrollees with risk factors related to sexual mode of transmission. • Enhanced case management outreach for HIV screening for enrollees 15–64 years of age without a diagnosis of HIV.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- The MCO developed and carried out a methodologically sound design for all five PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The MCO conducted and reported accurate analyses and interpretation of performance indicator results for all five PIPs. **[Quality]**
- The MCO carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCO collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all five PIPs. **[Quality]**
- For the three PIPs (*Behavioral Health Transitions of Care*, *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees*, and *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*) assessed for achieving significant improvement, the MCO's reported performance indicator results demonstrated some improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For ACLA, the following opportunities for improvement were identified:

- For the three PIPs (*Behavioral Health Transitions of Care*, *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees*, and *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*) assessed for achieving significant improvement, some but not all of the MCO's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For ACLA, the following recommendations were identified:

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

Methodology

Objectives

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

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

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

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

Technical Methods of Data Collection

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

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

1. HSAG evaluates the technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

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

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.

- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     – All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     – All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     – Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

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

How Conclusions Were Drawn

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

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of an MCO's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-10.

Table 2-10—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Topic	Quality	Timeliness	Access
Behavioral Health Transitions of Care	✓	✓	✓
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	✓	✓	✓
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	✓		✓
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	✓	✓	✓
Screening for HIV Infection	✓	✓	✓
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	✓	✓	✓

Results

Information Systems Standards Review

The MCO's independent certified HEDIS compliance auditor determined that the rates reported by the MCO were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified.

Based on a review of the FARs issued by ACLA's independent certified HEDIS compliance auditor, HSAG found that ACLA fully met the standard for all four of the applicable NCQA IS standards. ACLA's compliance with each of the IS standards is outlined in Table 3-1.

Table 3-1—ACLA Compliance With IS Standards—MY 2022 and MY 2023 Comparison

IS Standard	MY 2022	MY 2023
IS R—Data Management and Reporting (formerly IS 6.0, IS 7.0)	Met	Met
IS C—Clinical and Care Delivery Data (formerly IS 5.0)	Met	Met
IS M—Medical Record Review Processes (formerly IS 4.0)	Met	Met
IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	Met	Met

Performance Measures

In SFY 2024 (review period), LDH required each contracted MCO to collect and report on 47 HEDIS measures, which includes 290 total measure indicators for HEDIS MY 2023 specified in the provider agreement. The measurement set includes 11 incentive measures. Table 3-2 displays the 290 measure indicators required by LDH. **Red** cells indicate that the measure fell below the NCQA national 50th percentile, **green** cells indicate that the measure was at or above the NCQA national 50th percentile. Table 3-2 through Table 3-5 display a summary of ACLA's HEDIS measure performance.

Table 3-2—ACLA HEDIS Effectiveness of Care Performance Measures—MY 2022 and MY 2023 Comparison

HEDIS Measure	2022	2023	SWA
Follow-Up After Hospitalization for Mental Illness			
Within 7 Days of Discharge	18.77%	19.82%	**20.67%**
Within 30 Days of Discharge[I]	36.26%	38.49%	**39.62%**
Follow-Up After Emergency Department Visit for Mental Illness			
Within 7 Days of Discharge	22.93%	20.59%	**22.26%**
Within 30 Days of Discharge[I]	35.30%	31.59%	**36.83%**

HEDIS Measure	2022	2023	SWA
Follow-Up After Emergency Department Visit for Substance Use[B]			
Within 7 Days of Discharge	17.38%	12.51%	**13.46%**
Within 30 Days of Discharge[I]	28.94%	20.50%	**21.75%**
Plan All-Cause Readmissions*			
Observed Readmissions (Numerator/Denominator)	10.21%	10.73%	**10.13%**
Expected Readmissions Rate	9.65%	10.04%	**9.77%**
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.0574	1.0691	**1.0368**
Depression Screening and Follow-Up for Adolescents and Adults			
Depression Screening (Total)	2.59%	2.37%	**1.06%**
Follow-Up on Positive Screen (Total)	54.11%	51.12%	**62.50%**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.13%	84.73%	**84.36%**
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.07%	71.29%	**72.29%**
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	75.81%	80.00%	**81.53%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing	54.74%	54.61%	**54.92%**
Cholesterol Testing	29.05%	25.00%	**28.09%**
Blood Glucose and Cholesterol Testing	28.09%	24.42%	**27.21%**
Lead Screening in Children	66.91%	69.83%	**66.40%**
Childhood Immunization Status			
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	70.80%	71.28%	**71.31%**
Polio Vaccine, Inactivated (IPV)	88.81%	87.53%	**87.17%**
Measles, Mumps, and Rubella (MMR)	85.64%	86.28%	**86.06%**
Haemophilus Influenzae Type B (HiB)	85.16%	85.44%	**85.66%**
Hepatitis B	89.54%	90.29%	**89.20%**
Varicella-Zoster Virus (VZV)	85.64%	85.77%	**86.30%**
Pneumococcal Conjugate	69.34%	70.76%	**70.65%**
Hepatitis A	81.75%	84.15%	**83.82%**
Rotavirus	65.45%	66.61%	**63.96%**
Influenza	28.22%	20.30%	**21.26%**
Combination 3[I]	63.50%	64.95%	**64.96%**
Combination 7	54.26%	55.46%	**53.34%**
Combination 10	22.87%	16.04%	**16.16%**

HEDIS Measure	2022	2023	SWA
Immunizations for Adolescents			
Meningococcal	83.21%	84.67%	**85.85%**
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	83.70%	85.40%	**86.29%**
Human Papillomavirus (HPV)	40.39%	45.01%	**41.77%**
Combination 1	82.97%	84.67%	**85.64%**
Combination 2[I]	40.39%	44.77%	**41.53%**
Colorectal Cancer Screening[I]	35.17%	44.95%	**43.44%**
Flu Vaccinations for Adults Ages 18 to 64	40.86%	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
Body Mass Index (BMI) Percentile Documentation	73.20%	75.37%	**80.09%**
Counseling for Nutrition	62.28%	64.39%	**64.97%**
Counseling for Physical Activity	53.35%	62.20%	**57.89%**
HIV Viral Load Suppression[B, I]	75.50%	80.81%	**82.26%**
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	23.59%	25.06%	**26.35%**
Chlamydia Screening in Women			
Total	64.40%	64.32%	**65.84%**
Breast Cancer Screening	55.54%	—	—
Controlling High Blood Pressure[I]	59.90%	60.80%	**60.47%**
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	81.14%	83.76%	**82.74%**
Statin Adherence 80%—Total	67.81%	68.02%	**66.40%**
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes			
Poor HbA1c Control (>9.0%)[*,I]	39.66%	33.09%	**29.55%**
HbA1c Control (<8.0%)	53.04%	59.61%	**63.65%**
Eye Exam for Patients With Diabetes	50.36%	51.09%	**55.06%**
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)	56.20%	64.48%	**65.25%**
Pharmacotherapy for Opioid Use Disorder	29.55%	34.07%	**29.53%**
Initiation and Engagement of Substance Use Disorder (SUD) Treatment			
Initiation of SUD Treatment	64.68%	65.10%	**57.95%**
Engagement of SUD Treatment	28.33%	30.10%	**24.37%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	60.06%	56.83%	**63.06%**

HEDIS Measure	2022	2023	SWA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.42%	57.23%	**55.72%**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication			
Initiation Phase	40.70%	49.75%	**45.52%**
Continuation and Maintenance Phase	51.99%	56.83%	**54.23%**
Antidepressant Medication Management			
Effective Acute Phase Treatment	54.72%	56.31%	**57.61%**
Effective Continuation Phase Treatment	36.31%	38.89%	**39.77%**
Appropriate Treatment for Children With Upper Respiratory Infection	78.87%	80.40%	**80.50%**
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	53.82%	54.77%	**51.81%**
Use of Imaging Studies for Low Back Pain[B]	72.61%	69.88%	**69.31%**
Non-Recommended Cervical Screening in Adolescent Females[*]	2.08%	2.45%	**1.85%**
Cervical Cancer Screening[I]	55.36%	56.27%	**53.47%**
Asthma Medication Ratio			
5–11 Years	—	80.10%	**76.33%**
12–18 Years	—	72.42%	**69.59%**
19–50 Years	—	71.56%	**68.05%**
51–64 Years	—	69.89%	**67.00%**
Total	—	73.49%	**70.18%**
Topical Fluoride for Children			
1–2 Years	—	6.32%	**4.76%**
3–4 Years	—	9.66%	**6.32%**
Total	—	7.97%	**5.56%**
Oral Evaluation, Dental Services			
0–2 Years	—	NA	**NA**
3–5 Years	—	NA	**NA**
6–14 Years	—	NA	**NA**
15–20 Years	—	NA	**NA**
Total	—	NA	**NA**

[*] Indicates a lower rate is desirable.
[B] Indicates a break in trending between the most recent year and the prior year.
[I] Incentive Measure.
Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.
For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.
— is presented for measures that were not reported by the MCOs in MY 2022 and indicates that MY 2022 rates are not available for those measures.

Table 3-3—ACLA HEDIS Access to/Availability of Care Performance Measures—MY 2022 and MY 2023 Comparison

HEDIS Measure	MY 2022	MY 2023	SWA
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	68.28%	68.12%	**71.25%**
45–64 Years	78.39%	79.39%	**80.87%**
65 Years and Older	73.00%	76.08%	**79.46%**
Total	71.44%	71.66%	**74.25%**
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	85.67%	80.33%	**82.12%**
Postpartum Care	76.83%	73.77%	**77.27%**

Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.

Table 3-4—ACLA HEDIS Use of Services and Health Plan Descriptive Information Performance Measures—MY 2022 and MY 2023 Comparison

HEDIS Measure	MY 2022	MY 2023	SWA
Well-Child Visits in the First 30 Months of Life			
First 15 Months	58.63%	65.05%	**64.44%**
15 Months–30 Months	63.54%	69.78%	**70.10%**
Child and Adolescent Well-Care Visits			
3–11 Years	54.64%	57.12%	**57.47%**
12–17 Years	52.08%	53.65%	**54.10%**
18–21 Years	26.97%	28.92%	**29.30%**
Total	48.50%	51.04%	**51.39%**
Ambulatory Care			
Outpatient Visits/1,000 Member Years	4670.87	4,494.01	**4,958.45**
Emergency Department Visits/1,000 Member Year *	764.19	732.55	**735.72**
Inpatient Utilization—General Hospital/Acute Care			
Maternity—Days/1,000 Member Years—10–19 Years	—	30.40	**28.03**
Maternity—Days/1,000 Member Years—20–44 Years	—	147.31	**149.64**
Maternity—Days/1,000 Member Years—45–64 Years	—	2.10	**1.85**
Maternity—Days/1,000 Member Years—Total	—	80.47	**82.50**
Maternity—Discharges/1,000 Member Years—10–19 Years	—	10.17	**9.72**
Maternity—Discharges/1,000 Member Years—20–44 Years	—	52.99	**54.81**
Maternity—Discharges/1,000 Member Years—45–64 Years	—	0.66	**0.56**

HEDIS Measure	MY 2022	MY 2023	SWA
Maternity—Discharges/1,000 Member Years—Total	—	28.68	**30.03**
Maternity—Average Length of Stay—10–19 Years	—	2.99	**2.88**
Maternity—Average Length of Stay—20–44 Years	—	2.78	**2.73**
Maternity—Average Length of Stay—45–64 Years	—	3.16	**3.29**
Maternity—Average Length of Stay—Total	—	2.81	**2.75**
Surgery—Days/1,000 Member Years—Less than 1 Year	—	315.98	**463.70**
Surgery—Days/1,000 Member Years—1–9 Years	—	23.41	**33.47**
Surgery—Days/1,000 Member Years—10–19 Years	—	31.24	**32.49**
Surgery—Days/1,000 Member Years—20–44 Years	—	103.34	**106.78**
Surgery—Days/1,000 Member Years—45–64 Years	—	359.41	**356.86**
Surgery—Days/1,000 Member Years—65–74 Years	—	266.28	**393.71**
Surgery—Days/1,000 Member Years—75–84 Years	—	695.44	**944.71**
Surgery—Days/1,000 Member Years—86 Years	—	NA	**584.92**
Surgery—Days/1,000 Member Years—Total	—	112.99	**123.56**
Surgery—Discharges/1,000 Member Years—Less than 1 Year	—	17.48	**19.95**
Surgery—Discharges/1,000 Member Years—1–9 Years	—	3.39	**3.54**
Surgery—Discharges/1,000 Member Years—10–19 Years	—	3.96	**4.35**
Surgery—Discharges/1,000 Member Years—20–44 Years	—	13.28	**14.26**
Surgery—Discharges/1,000 Member Years—45–64 Years	—	42.99	**42.97**
Surgery—Discharges/1,000 Member Years—65–74 Years	—	34.73	**42.16**
Surgery—Discharges/1,000 Member Years—75–84 Years	—	73.98	**87.74**
Surgery—Discharges/1,000 Member Years—85 Years and Older	—	NA	**51.79**
Surgery—Discharges/1,000 Member Years—Total	—	13.48	**14.43**
Surgery—Average Length of Stay—Less than 1 Year	—	18.08	**23.24**
Surgery—Average Length of Stay—1–9 Years	—	6.91	**9.44**
Surgery—Average Length of Stay—10–19 Years	—	7.89	**7.46**
Surgery—Average Length of Stay—20–44 Years	—	7.78	**7.49**
Surgery—Average Length of Stay—45–64 Years	—	8.36	**8.31**
Surgery—Average Length of Stay—65–74 Years	—	7.67	**9.34**
Surgery—Average Length of Stay—75–84 Years	—	9.40	**10.77**
Surgery—Average Length of Stay—85 Years and Older	—	NA	**11.29**
Surgery—Average Length of Stay—Total	—	8.38	**8.56**
Medicine—Days/1,000 Member Years—Less than 1 Year	—	447.26	**414.29**

HEDIS Measure	MY 2022	MY 2023	SWA
Medicine—Days/1,000 Member Years—1–9 Years	—	38.43	**40.91**
Medicine—Days/1,000 Member Years—10–19 Years	—	29.34	**27.72**
Medicine—Days/1,000 Member Years—20–44 Years	—	117.80	**108.57**
Medicine—Days/1,000 Member Years—45–64 Years	—	442.70	**393.48**
Medicine—Days/1,000 Member Years—65–74 Years	—	396.53	**550.81**
Medicine—Days/1,000 Member Years—75–84 Years	—	547.47	**921.88**
Medicine—Days/1,000 Member Years—85 Years and Older	—	NA	**1,617.67**
Medicine—Days/1,000 Member Years—Total	—	137.61	**129.96**
Medicine—Discharges/1,000 Member Years—Less than 1 Year	—	78.27	**75.93**
Medicine—Discharges/1,000 Member Years—1–9 Years	—	11.42	**11.75**
Medicine—Discharges/1,000 Member Years—10–19 Years	—	7.36	**7.45**
Medicine—Discharges/1,000 Member Years—20–44 Years	—	26.16	**23.27**
Medicine—Discharges/1,000 Member Years—45–64 Years	—	81.79	**73.88**
Medicine—Discharges/1,000 Member Years—65–74 Years	—	89.73	**99.37**
Medicine—Discharges/1,000 Member Years—75–84 Years	—	103.58	**158.65**
Medicine—Discharges/1,000 Member Years—85 Years and Older	—	NA	**164.51**
Medicine—Discharges/1,000 Member Years—Total	—	28.34	**26.76**
Medicine—Average Length of Stay—Less than 1 Year	—	5.71	**5.46**
Medicine—Average Length of Stay—1–9 Years	—	3.36	**3.48**
Medicine—Average Length of Stay—10–19 Years	—	3.99	**3.72**
Medicine—Average Length of Stay—20–44 Years	—	4.50	**4.67**
Medicine—Average Length of Stay—45–64 Years	—	5.41	**5.33**
Medicine—Average Length of Stay—65–74 Years	—	4.42	**5.54**
Medicine—Average Length of Stay—75–84 Years	—	5.29	**5.81**
Medicine—Average Length of Stay—85 Years and Older	—	NA	**9.83**
Medicine—Average Length of Stay—Total	—	4.86	**4.86**
Total Inpatient—Days/1,000 Member Years—Less than 1 Year	—	763.24	**877.99**
Total Inpatient—Days/1,000 Member Years—1–9 Years	—	61.84	**74.37**
Total Inpatient—Days/1,000 Member Years—10–19 Years	—	90.99	**88.24**
Total Inpatient—Days/1,000 Member Years—20–44 Years	—	368.44	**364.98**
Total Inpatient—Days/1,000 Member Years—45–64 Years	—	804.21	**752.20**
Total Inpatient—Days/1,000 Member Years—65–74 Years	—	662.81	**944.52**

HEDIS Measure	MY 2022	MY 2023	SWA
Total Inpatient—Days/1,000 Member Years—75–84 Years	—	1,242.91	**1,866.59**
Total Inpatient—Days/1,000 Member Years—85 Years and Older	—	NA	**2,202.59**
Total Inpatient—Days/1,000 Member Years—Total	—	309.98	**315.49**
Total Inpatient—Discharges/1,000 Member Years—Less than 1 Year	—	95.75	**95.88**
Total Inpatient—Discharges/1,000 Member Years—1–9 Years	—	14.81	**15.29**
Total Inpatient—Discharges/1,000 Member Years—10–19 Years	—	21.48	**21.53**
Total Inpatient—Discharges/1,000 Member Years—20–44 Years	—	92.43	**92.34**
Total Inpatient—Discharges/1,000 Member Years—45–64 Years	—	125.44	**117.41**
Total Inpatient—Discharges/1,000 Member Years—65–74 Years	—	124.46	**141.53**
Total Inpatient—Discharges/1,000 Member Years—75–84 Years	—	177.56	**246.39**
Total Inpatient—Discharges/1,000 Member Years—85 Years and Older	—	NA	**216.30**
Total Inpatient—Discharges/1,000 Member Years—Total	—	62.98	**63.75**
Total Inpatient—Average Length of Stay—Less than 1 Year	—	7.97	**9.16**
Total Inpatient—Average Length of Stay—1–9 Years	—	4.23	**4.10**
Total Inpatient—Average Length of Stay—10–19 Years	—	4.18	**4.86**
Total Inpatient—Average Length of Stay—20–44 Years	—	3.99	**3.95**
Total Inpatient—Average Length of Stay—45–64 Years	—	6.41	**6.41**
Total Inpatient—Average Length of Stay—65–74 Years	—	5.33	**6.67**
Total Inpatient—Average Length of Stay—75–84 Years	—	7.00	**7.58**
Total Inpatient—Average Length of Stay—85 Years and Older	—	NA	**10.18**
Total Inpatient—Average Length of Stay—Total	—	4.92	**4.95**
Enrollment by Product Line			
Less than 1 year	—	5,150	**39,430**
1–4 Years	—	20,015	**154,688**
5–9 Years	—	23,939	**194,614**
10–14 Years	—	22,337	**187,448**
15–17 Years	—	13,656	**113,890**
18–19 Years	—	8,181	**67,190**
20–24 Years	—	17,206	**144,726**
25–29 Years	—	13,753	**119,861**
30–34 Years	—	13,567	**117,909**

HEDIS Measure	MY 2022	MY 2023	SWA
35–39 Years	—	11,853	**102,144**
40–44 Years	—	10,296	**90,116**
45–49 Years	—	8,036	**68,991**
50–54 Years	—	6,878	**61,320**
55–59 Years	—	7,176	**60,505**
60–64 Years	—	6,623	**57,221**
65–69 Years	—	267	**3,396**
70–74 Years	—	82	**1,046**
75–79 Years	—	38	**592**
80–84 Years	—	NA	**421**
85–89 Years	—	NA	**224**
90 Years and Older	—	NA	**173**
Unknown	—	NA	**NA**
Total	—	189,108	**1,585,904**
Language Diversity of Membership			
Spoken Language Preferred for Health Care—Health Plan	—	39.04%	**23.84%**
Spoken Language Preferred for Health Care—CMS/State	—	60.93%	**76.01%**
Spoken Language Preferred for Health Care—Other Third-Party	—	0.04%	**0.15%**
Preferred Language for Written Materials—Health Plan	—	38.51%	**23.78%**
Preferred Language for Written Materials—CMS/State	—	61.45%	**52.79%**
Preferred Language for Written Materials—Other Third-Party	—	0.04%	**23.43%**
Other Language Needs—Health Plan	—	0.16%	**19.20%**
Other Language Needs—CMS/State	—	99.79%	**47.96%**
Other Language Needs—Other Third-Party	—	0.06%	**32.83%**
Spoken Language Preferred for Health Care—Percent English	—	96.88%	**89.10%**
Spoken Language Preferred for Health Care—Percent Non-English	—	3.05%	**1.78%**
Spoken Language Preferred for Health Care—Percent Declined	—	0.00%	**0.00%**
Spoken Language Preferred for Health Care—Percent Unknown	—	0.07%	**9.12%**
Language Preferred for Written Materials—Percent English	—	96.87%	**66.23%**
Language Preferred for Written Materials—Percent Non-English	—	3.06%	**1.37%**
Language Preferred for Written Materials—Percent Declined	—	0.00%	**0.00%**

HEDIS Measure	MY 2022	MY 2023	SWA
Language Preferred for Written Materials—Percent Unknown	—	0.07%	**32.40%**
Other Language Needs—Percent English	—	98.17%	**47.18%**
Other Language Needs—Percent Non-English	—	1.78%	**0.80%**
Other Language Needs—Percent Declined	—	0.00%	**0.00%**
Other Language Needs—Percent Unknown	—	0.06%	**52.02%**
Race/Ethnicity Diversity of Membership			
Race—Health Plan	—	35.80%	**22.17%**
Race—CMS/State	—	53.72%	**56.65%**
Race—Other Direct	—	0.00%	**0.43%**
Race—Direct Total	—	89.52%	**79.25%**
Race—Indirect Total	—	0.00%	**0.61%**
Race—Unknown Total	—	10.48%	**20.14%**
Ethnicity—Health Plan	—	41.41%	**22.63%**
Ethnicity—CMS/State	—	8.93%	**35.49%**
Ethnicity—Other Direct	—	0.00%	**2.20%**
Ethnicity—Direct Total	—	50.33%	**60.32%**
Ethnicity—Indirect Total	—	0.00%	**8.74%**
Ethnicity—Unknown Total	—	49.67%	**30.93%**
Race: White—Ethnicity: Hispanic or Latino	—	4.05%	**0.81%**
Race: White—Ethnicity: Not Hispanic or Latino	—	14.51%	**28.15%**
Race: White—Ethnicity: Asked but No Answer	—	0.17%	**0.02%**
Race: White—Ethnicity: Unknown	—	16.51%	**7.88%**
Race: White—Ethnicity: Total	—	35.24%	**36.87%**
Race: Black or African American—Ethnicity: Hispanic or Latino	—	4.94%	**0.67%**
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	21.23%	**25.38%**
Race: Black or African American—Ethnicity: Asked but No Answer	—	0.22%	**0.03%**
Race: Black or African American—Ethnicity: Unknown	—	22.96%	**11.17%**
Race: Black or African American—Ethnicity: Total	—	49.35%	**37.26%**
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	0.12%	**0.03%**
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	0.30%	**0.48%**

HEDIS Measure	MY 2022	MY 2023	SWA
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	0.35%	**0.21%**
Race: American Indian or Alaska Native—Ethnicity: Total	—	0.78%	**0.72%**
Race: Asian—Ethnicity: Hispanic or Latino	—	0.15%	**0.04%**
Race: Asian—Ethnicity: Not Hispanic or Latino	—	0.46%	**1.58%**
Race: Asian—Ethnicity: Asked but No Answer	—	0.01%	**0.00%**
Race: Asian—Ethnicity: Unknown	—	0.77%	**1.02%**
Race: Asian—Ethnicity: Total	—	1.38%	**2.64%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	0.02%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	0.03%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	—	0.03%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	0.08%	**0.02%**
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	0.00%	**0.15%**
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.68%**
Race: Some Other Race—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Some Other Race—Ethnicity: Unknown	—	0.00%	**1.19%**
Race: Some Other Race—Ethnicity: Total	—	0.00%	**2.02%**
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	1.21%	**0.14%**
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	0.14%	**0.02%**
Race: Two or More Races—Ethnicity: Asked but No Answer	—	0.01%	**0.00%**
Race: Two or More Races—Ethnicity: Unknown	—	1.34%	**0.16%**
Race: Two or More Races—Ethnicity: Total	—	2.70%	**0.33%**
Race: Unknown—Ethnicity: Hispanic or Latino	—	2.04%	**0.83%**
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	0.68%	**7.38%**
Race: Unknown—Ethnicity: Asked but No Answer	—	0.04%	**2.65%**
Race: Unknown—Ethnicity: Unknown	—	7.72%	**9.27%**
Race: Unknown—Ethnicity: Total	—	10.48%	**20.14%**
Race: Total—Ethnicity: Hispanic or Latino	—	12.53%	**2.67%**

HEDIS Measure	MY 2022	MY 2023	SWA
Race: Total—Ethnicity: Not Hispanic or Latino	—	37.35%	**63.68%**
Race: Total—Ethnicity: Asked but No Answer	—	0.45%	**2.71%**
Race: Total—Ethnicity: Unknown	—	49.67%	**30.93%**
Race: Total—Ethnicity: Total	—	100.00%	**100.00%**
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Unknown	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Total	—	0.00%	**0.00%**

* Indicates a lower rate is desirable.
Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.
For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.
— is presented for measures that were not reported by the MCOs in MY 2022 and indicates that MY 2022 rates are not available for those measures.

Table 3-5—ACLA HEDIS Performance Measure Summary—MY 2022 and MY 2023 Comparison

Measure Status	MY 2022	MY 2023*
≥ NCQA National 50th Percentile Benchmark	31	173
< NCQA National 50th Percentile Benchmark	47	94
NCQA National Benchmark Unavailable	11	12
Total	89	279

*The "Total" row presents the count of all HEDIS measure indicators that could be reported by MCOs for MY 2023, excluding indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NB* (i.e., MCO did not provide the health benefit), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator). The "≥ NCQA National 50th Percentile Benchmark," "< NCQA National 50th Percentile Benchmark," and "NCQA National Benchmark Unavailable" rows present the count of indicators with reportable rates, for each MCO, that met the comparison criteria. For MY 2023, measure indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator) are excluded from the comparison rows because their results are not comparable to NCQA benchmarks.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- ACLA's rate on the *Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening (Total)* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA was effective in coordinating with providers to ensure

adolescent and adult Medicaid members were properly screened for depression, enabling timely follow-up care. **[Quality]**

- ACLA's rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was above the NCQA national 50th percentile benchmark for MY 2023. Additionally, ACLA's rate on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA was effective in ensuring that adult members on antipsychotics were screened for diabetes and had their diabetes monitored, resulting in positive health outcomes for this population. **[Quality]**
- ACLA's rate on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA was effective in ensuring that adult members with cardiovascular disease and schizophrenia had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- ACLA's rate on the *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA was effective in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- ACLA's rate on the following *Childhood Immunization Status* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *DTaP*, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Hepatitis A*, and *Combination 3*. These results suggest that ACLA was effective in ensuring that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease. **[Quality and Access]**
- ACLA's rate on the following *Immunizations for Adolescents* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *Meningococcal*, *Tdap/TD*, *HPV*, *Combination 1*, and *Combination 2*. These results suggest that ACLA was effective in ensuring that adolescent members were receiving immunizations to help protect them against meningococcal disease, tetanus, diphtheria, pertussis, and HPV. **[Quality]**
- ACLA's rate on the *Colorectal Cancer Screening* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA was effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- ACLA's rate on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- ACLA's rate on the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA effectively coordinated with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) received statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- ACLA's rates on the *HbA1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators were above the NCQA national 50th percentile

benchmark for MY 2023. These results suggest that ACLA effectively coordinated with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**

- ACLA's rate on the *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA effectively coordinated with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- ACLA's rates on the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* and *Engagement of SUD Treatment* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA effectively coordinated with providers to initiate treatment for members with a new SUD episode and engaged these members in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment. **[Quality, Timeliness, and Access]**
- ACLA's rates on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA effectively coordinated with providers to ensure that children prescribed ADHD medication participated in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**
- ACLA's rates on the following *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *5–11 Years*, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*. These results suggest that ACLA effectively coordinated with providers to help members with persistent asthma manage this treatable condition. **[Quality]**
- ACLA's rates on the *Well-Child Visits in the First 30 Months of Life—First 15 Months* and *15 Months–30 Months* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA effectively coordinated with PCPs to ensure that children were seen within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**
- ACLA's rates on the *Child and Adolescent Well-Care Visits—12–17 Years* and *18–21 Years* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA effectively coordinated with providers to ensure that adolescent members received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For ACLA, the following opportunities for improvement were identified:

- ACLA's rates on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA has room for improvement in their coordination with providers to ensure that members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. **[Quality, Timeliness, and Access]**
- ACLA's rates on the *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA

national 50th percentile benchmark for MY 2023. Additionally, ACLA's rates on the *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA has room for improvement with properly managing the care of patients discharged after an emergency department (ED) visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**

- ACLA's rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- ACLA's rate on the *Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen (Total)* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers to ensure adolescent and adult Medicaid members were properly screened for depression, enabling timely follow-up care. **[Quality]**
- ACLA's rates on the following *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *Blood Glucose Testing*, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*. These results suggest that ACLA has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- ACLA's rates on the following *Childhood Immunization Status* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *Pneumococcal Conjugate*, *Rotavirus*, *Influenza*, *Combination 7*, and *Combination 10*. These results suggest that ACLA has room for improvement in coordinating with providers to ensure children under 2 years of age are receiving all appropriate vaccinations to protect them against potential life-threatening diseases. **[Quality and Access]**
- ACLA's rates on the following *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *BMI Percentile Documentation*, *Counseling for Nutrition*, and *Counseling for Physical Activity*. These results suggest that ACLA has room for improvement in coordinating with providers to ensure that child and adolescent members are having their weight and BMI monitored, and are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- ACLA's rate on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- ACLA's rate on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers

to ensure that members with ASCVD adhere to statin therapy to effectively manage their condition. **[Quality]**

- ACLA's rate on the *Eye Exam for Patients With Diabetes* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers to ensure that adult members with diabetes receive a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- ACLA's rate on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- ACLA's rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA has room for improvement in coordinating with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- ACLA's rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder are dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- ACLA's rates on the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA has room for improvement in coordinating with providers to treat adult members diagnosed with major depression with antidepressant medication and help members remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**
- ACLA's rate on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement with ensuring that a diagnosis of upper respiratory infection (URI) does not result in an antibiotic dispensing event for members. **[Quality]**
- ACLA's rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- ACLA's rate on the *Use of Imaging Studies for Low Back Pain* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- ACLA's rate on the *Non-Recommended Cervical Screening in Adolescent Females* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement with ensuring that providers avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**

- ACLA's rate on the *Cervical Cancer Screening* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers to ensure that women ages 21 to 64 years receive appropriate, early detection cancer screening. **[Quality]**
- ACLA's rates on the following *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *20–44 Years*, *45–64 Years*, *65 Years and Older*, and *Total*. These results suggest that ACLA has room for improvement in coordinating with PCPs to ensure that adult members are engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- ACLA's rates on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ACLA has room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care, in alignment with guidance provided by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**
- ACLA's rate on the *Child and Adolescent Well-Care Visits—3–11 Years* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ACLA has room for improvement in coordinating with providers to ensure that adolescent members receive appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For ACLA, the following recommendations were identified:

- To improve performance on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, and *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators, HSAG recommends that ACLA work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and ACLA. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**
- To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommends that ACLA work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen (Total)* measure indicator, HSAG recommends that ACLA work with providers to identify and address barriers to follow-up care for members who are positively screened for depression. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions to improve follow-up care for members screened for depression. **[Quality]**

- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators, HSAG recommends that ACLA work with providers to identify root causes and trial interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**
- To improve performance on the *Childhood Immunization Status* measure indicators, HSAG recommends that ACLA focus its efforts on increasing immunizations for children. ACLA should also consider conducting a root cause analysis and implementing appropriate interventions to improve performance that are evidence-based and address barriers such as parent dissatisfaction, provider capacity, or appointment accessibility. Additionally, ACLA should consider inclusion of parent/guardian and provider participation when evaluating root causes of measure performance. **[Quality and Access]**
- To improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, HSAG recommends that ACLA work with PCPs to identify and address barriers to primary care visits for children and adolescents in need of weight assessment and education on healthy habits. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality]**
- To improve performance on the *Controlling High Blood Pressure* measure, HSAG recommends that ACLA work with providers to identify and address barriers to effective blood pressure management in members. ACLA could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, ACLA could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator, HSAG recommends that ACLA work with providers to identify and address barriers to statin therapy adherence among members with ASCVD. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as provider and member education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that ACLA work with providers to identify and address barriers to retinal eye exams for members with diabetes. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education and outreach campaigns. **[Quality]**
- To improve performance on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure, HSAG recommends that ACLA work with providers to identify and address barriers to

effective blood pressure management for diabetic members. HSAG also recommends that ACLA expand on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**

- To improve performance on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure, HSAG recommends that ACLA work with providers to reduce the use of antipsychotics as the first-line treatment and trial solutions to promote psychosocial care as the primary method for addressing the behavioral health needs of child and adolescent members. **[Quality]**
- To improve performance on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that ACLA work with providers to identify and address barriers to the dispensing of antipsychotic medications to members with schizophrenia or schizoaffective disorder, and barriers to adherence to antipsychotic medications. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as provider education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators, HSAG recommends that ACLA work with providers to identify and address barriers to prescribing antidepressant medication to adult members with major depression and helping members remain on antidepressant medication for the appropriate amount of time. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, HSAG recommends that ACLA work with providers to trial solutions to reduce antibiotic dispensing to treat URI. ACLA could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, HSAG recommends that ACLA work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. ACLA could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that ACLA focus its efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that ACLA work with providers to trial solutions to reduce the inappropriate ordering of imaging studies. Appropriate interventions to improve performance may

include addressing provider behaviors, provider incentives, and addressing member expectation with education. **[Quality]**

- To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommends that ACLA work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- To improve performance on the *Cervical Cancer Screening* measure, HSAG recommends that ACLA work with providers to identify and address barriers to cervical cancer screening for women ages 21 to 64 years old. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as offering screenings at more locations or expanding clinic and screening hours. **[Quality]**
- To improve performance on the *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, HSAG recommends that ACLA work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**
- To improve performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, HSAG recommends that ACLA work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. HSAG recommends ACLA consider implementing interventions such as offering provider education and engagement opportunities, including educational webinars and newsletters on prenatal and postpartum health services, and piloting a member incentives program designed to encourage engagement in timely prenatal and postpartum care services. **[Quality, Timeliness, and Access]**
- To improve performance on the *Child and Adolescent Well-Care Visits—3–11 Years* measure indicator, HSAG recommends that ACLA work with providers to identify and address barriers to well-care visits for children. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, sending reminders, and incentives for members upon completion of the well-child visits. **[Quality and Access]**

Methodology

Objectives

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

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

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

Technical Methods of Data Collection

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[3-1] specifies that, in lieu of conducting a full on-site Information Systems Capabilities Assessment (ISCA), the EQRO may review an assessment of the MCO's IS conducted by another party. If an MCO is accredited by NCQA, the MCO will have received a full IS assessment as part of its annual HEDIS Compliance Audit by an NCQA HEDIS Compliance Audit licensed organization (LO). In this case, HSAG would request and review the MCO's NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap), FAR, and the data submission tool in lieu of conducting an on-site assessment.

The validation process is described separately for the HEDIS and non-HEDIS measures that the MCOs report.

HEDIS Measure Validation

The MCOs that report HEDIS measures to NCQA must undergo an audit of their data conducted by an NCQA HEDIS Compliance Audit LO. For these HEDIS measures, HSAG reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

measure rates and any problems that the MCOs experienced in the HEDIS process. Included in the FAR are the measures deemed *Not Reportable* due to biases in the calculation process.

HSAG used the results of the audit to report the results of each measure reported to LDH. Using information provided in the FAR and, if necessary, additional documentation (i.e., NCQA HEDIS Roadmap), HSAG prepared a report indicating the measure results for each of the MCOs that are required to report to LDH. Measures deemed *Not Reportable* were flagged. SWAs were computed, and NCQA Quality Compass benchmarks were provided as well. Results for the prior two years were provided for trending, when appropriate. Any issues in reporting any measure (e.g., medical record abstraction issues) were noted and, if LDH requested any other statistical analyses, the results were included in the report.

Non-HEDIS Measure Validation

For state-specific measures and standardized non-HEDIS measures (e.g., the Prevention Quality Indicators), University of Louisiana Monroe (ULM), contracted by LDH, conducted the audit. Measures that did not pass validation were deemed *Not Reportable*, and the reasons for this designation (e.g., unresolved source code issues) were noted. If LDH requested any other statistical analyses, the results were included in the report. ULM conducted the validation for non-HEDIS measures, and HSAG provided assistance when needed.

Description of Data Obtained

HSAG used the FAR and the MCO rates provided on the IDSS file as the primary data sources. The FAR included information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, medical record review validation results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. The FAR included final determinations of validity made by the auditor for each performance measure. The IDSS file detailed all rates that were submitted to NCQA and whether the auditor deemed them to be reportable. The IDSS file is "locked" by the auditor so that no changes can be made to the results.

How Data Were Aggregated and Analyzed

In accordance with the MY 2023 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. For each HEDIS measure, the MCO was evaluated on how its rate compared to the NCQA Quality Compass MY 2023 national 50th percentile Medicaid HMO benchmark.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the MY 2023 performance levels based on comparison to the NCQA national 50th percentile benchmark percentile to identify strengths and opportunities for improvement and determine whether each strength and opportunity for improvement impacted one or more of the domains of quality, timeliness, or access. Additionally, for each opportunity for improvement, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCO's Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-6. The measures marked *NA* are related to utilization of services.

Table 3-6—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Childhood Immunization Status—DTaP, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Pneumococcal Conjugate, Hepatitis A*, *Rotavirus*, *Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*	✓		✓
Immunizations for Adolescents—Meningococcal, *Tdap/Td*, *HPV*, *Combination 1*, and *Combination 2*	✓		
Colorectal Cancer Screening	✓		
Cervical Cancer Screening	✓		
Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
HbA1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%) and *HbA1c Control (<8.0%)*	✓		
Controlling High Blood Pressure	✓		
HIV Viral Load Suppression	✓		
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)	✓		
Child and Adolescent Well-Care Visits—3–11 Years, *12–17 Years*, *18–21 Years*, and *Total*	✓		✓
Well-Child Visits in the First 30 Months of Life—First 15 Months and *15 Months–30 Months*	✓		✓

Performance Measure	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Ambulatory Care—Outpatient Visits/1,000 Member Years and *Emergency Department Visits/1,000 Member Years*	NA	NA	NA
Plan All-Cause Readmissions—Observed Readmissions, *Expected Readmissions*, and *O/E Ratio*	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Flu Vaccinations for Adults Ages 18 to 64	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation, *Counseling for Nutrition*, and *Counseling for Physical Activity*	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total and *Statin Adherence 80%—Total*	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Eye Exam for Patients With Diabetes	✓		
Pharmacotherapy for Opioid Use Disorder	✓		
Initiation and Engagement of SUD Treatment—Initiation of SUD and *Engagement of SUD*	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		

Performance Measure	Quality	Timeliness	Access
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Non-Recommended Cervical Screening in Adolescent Females	✓		
Depression Screening and Follow-Up for Adolescents and Adults	✓		
Self-Reported Overall Health (Adult)—Adult—Very Good and *Adult—Excellent*	✓		
Asthma Medication Ratio—5–11 Years, *12–18 Years*, *19–50 Years, 51–64 Years*, and *Total*	✓		
Topical Fluoride for Children—1–2 Years, *3–4 Years*, and *Total*	✓		
Oral Evaluation, Dental Services—0–2 Years, *3–5 Years*, *6–14 Years*, *15–20 Years*, and *Total*	✓		
Use of Imaging Studies for Low Back Pain	✓		
Inpatient Utilization—General Hospital/Acute Care—Maternity, *Surgery*, *Medicine*, and *Total Inpatient*	NA	NA	NA
Enrollment by Product Line	NA	NA	NA
Language Diversity of Membership	NA	NA	NA
Race/Ethnicity Diversity of Membership	NA	NA	NA

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

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

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

Standard Name	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Enrollment and Disenrollment[2]		**100%[2]**	
Member Rights and Confidentiality	99.1%		
Member Information			
Coverage and Authorization of Services	99.2%		
Emergency and Post-Stabilization Services			
Availability of Services	95.0%		
Assurances of Adequate Capacity and Services	100%		
Coordination and Continuity of Care	95.2%		
Provider Selection	100%		
Subcontractual Relationships and Delegation	100%		
Practice Guidelines	100%		
Health Information Systems	100%		
Quality Assessment and Performance Improvement Program	98.6%		
Grievance and Appeal Systems	100%		
Program Integrity	100%		

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

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

Follow-Up on Previous Compliance Review Findings

Following the year two CR, HSAG worked with LDH to issue CAPs for elements in Standard I—Enrollment and Disenrollment that were not compliant. The MCOs were required to submit the CAP for approval. Upon approval from LDH and HSAG, the MCOs were required to implement the CAP and submit evidence of implementation. HSAG worked with LDH to review, approve, and monitor CAPs during SFY 2023.

ALCA achieved compliance in one of one element from the 2023 CAPs, demonstrating positive improvements in implementing CAPs from 2023.

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

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

For ACLA, the following opportunities for improvement were identified:

- HSAG did not identify any opportunities for improvement.

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

- HSAG did not identify any required actions or recommendations.

Methodology

Standards

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

Table 4-2—Summary of CR Standards

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

NA=not applicable for the PAHPs

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

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

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

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

Objectives

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

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

Technical Methods of Data Collection

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

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

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

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw

conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the MCOs. Table 4-5 depicts assignment of the standards to the domains of care.

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

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

Results

Provider Directory Accuracy

HSAG conducted PDV reviews from July 2023 through November 2023 (review period). This section presents the results from the CY 2023 PDV for all sampled ACLA providers by specialty type across all four quarters.

Table 5-1 illustrates the response rate and indicator match rates for ACLA by specialty type.

Table 5-1—Response Rate and Indicator Match Rates for ACLA by Specialty Type

Specialty Type	Response Rate		Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**437**	**87.4%**	**354**	**81.0%**	**353**	**80.8%**	**332**	**76.0%**	**306**	**70.0%**	**297**	**68.0%**	**329**	**75.3%**
Internal Medicine/ Family Medicine	89	89.0%	67	75.3%	72	80.9%	67	75.3%	54	60.7%	51	57.3%	60	67.4%
Pediatrics	95	95.0%	76	80.0%	75	78.9%	70	73.7%	67	70.5%	63	66.3%	71	74.7%
OB/GYN	89	89.0%	72	80.9%	78	87.6%	73	82.0%	70	78.7%	70	78.7%	75	84.3%
Specialists (any)	90	90.0%	75	83.3%	68	75.6%	65	72.2%	59	65.6%	61	67.8%	66	73.3%
Behavioral Health (any)	74	74.0%	64	86.5%	60	81.1%	57	77.0%	56	75.7%	52	70.3%	57	77.0%

Table 5-2 presents ACLA's PDV weighted compliance scores by specialty type. Please see the NAV methodology for the weighted compliance score calculation criteria.

Table 5-2—PDV Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**500**	**225**	**50.8%**
Internal Medicine/Family Medicine	100	34	40.7%
Pediatrics	100	46	53.3%

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
OB/GYN	100	57	64.0%
Specialists (any)	100	47	52.0%
Behavioral Health (any)	100	41	44.0%

[1] Compliant providers include providers for which all indicators match between the online provider directory and the information obtained during the survey call to the sampled location.

Table 5-3 presents ACLA's reasons for noncompliance.

Table 5-3—Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**275**	**55.0%**
Total reasons for noncompliance[1]	**325**	**NA**
Provider does not participate with MCO or Louisiana Medicaid	61	12.2%
Provider is not at site	77	15.4%
Provider not accepting new patients	24	4.8%
Wrong telephone number	1	0.2%
No response/busy signal/disconnected telephone number (after three calls)	58	11.6%
Representative does not know	0	0.0%
Incorrect address reported	69	13.8%
Address (suite number) needs to be updated	14	2.8%
Wrong specialty reported	21	4.2%

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.
NA = a rate was not calculated for this element.

Provider Access Surveys

HSAG conducted provider access surveys in September 2023 and November to December 2023 (review period). This section presents the results from the CY 2023 provider access surveys for all sampled providers by MCO and specialty type.

Table 5-4 illustrates the response rate and indicator match rates for ACLA by specialty type.

Table 5-4—Response Rate and Indicator Match Rates for ACLA by Specialty Type

Specialty Type	Response Rate		Correct Address		Offered Requested Services		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients		Provider at Location	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**140**	**73.3%**	**123**	**87.9%**	**101**	**72.1%**	**84**	**60.0%**	**82**	**58.6%**	**73**	**52.1%**	**64**	**45.7%**
Primary Care	37	61.7%	31	83.8%	27	73.0%	21	56.8%	19	51.4%	17	45.9%	13	35.1%
Pediatrics	25	62.5%	22	88.0%	18	72.0%	17	68.0%	17	68.0%	15	60.0%	14	56.0%
OB/GYNs	17	85.0%	15	88.2%	13	76.5%	11	64.7%	11	64.7%	10	58.8%	9	52.9%
Endocrinologists	15	78.9%	13	86.7%	11	73.3%	9	60.0%	9	60.0%	9	60.0%	9	60.0%
Dermatologists	12	100%	11	91.7%	10	83.3%	8	66.7%	8	66.7%	7	58.3%	7	58.3%
Neurologists	18	90.0%	16	88.9%	11	61.1%	9	50.0%	9	50.0%	8	44.4%	6	33.3%
Orthopedic Surgeons	16	80.0%	15	93.8%	11	68.8%	9	56.3%	9	56.3%	7	43.8%	6	37.5%

Table 5-5 illustrates the average new patient wait times and appointments meeting compliance standards for ACLA by appointment type.

Table 5-5—Average New Patient Wait Times and Appointments Meeting Compliance Standards for ACLA by Appointment Type

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Routine Primary Care Visit	9	80.0%
Routine Pediatric Visit	5	100%
Non-Urgent Sick Primary Care Visit	3	80.0%
Non-Urgent Sick Pediatric Visit	2	66.7%
OB/GYN Visit	15	33.3%
Endocrinologist Visit	109	0.0%

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Dermatologist Visit	41	75.0%
Neurologist Visit	38	50.0%
Orthopedic Surgeon Visit	48	0.0%

Table 5-6 presents ACLA's provider access survey weighted compliance scores by specialty type. Please see the network adequacy validation (NAV) methodology for the weighted compliance score calculation criteria.

Table 5-6—Provider Access Survey Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**191**	**64**	**43.8%**
Primary Care	60	13	29.4%
Pediatrics	40	14	44.2%
OB/GYNs	20	9	55.0%
Endocrinologists	19	9	57.9%
Dermatologists	12	7	61.1%
Neurologists	20	6	50.0%
Orthopedic Surgeons	20	6	45.0%

[1] Compliant providers include providers for which all indicators match between the online provider directory and the information obtained during the survey call to the sampled location.

Table 5-7 presents ACLA's provider access survey reasons for noncompliance.

Table 5-7—Provider Access Survey Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**127**	**66.5%**
Total reasons for noncompliance[1]	**129**	**NA**
Provider does not participate with MCO or Louisiana Medicaid	19	9.9%
Provider is not at site	9	4.7%
Provider not accepting new patients	9	4.7%
Wrong telephone number	6	3.1%

Reason	Count	Rate (%)
No response/busy signal/disconnected telephone number (after three calls)	46	24.1%
Incorrect address reported	17	8.9%
Address (suite number) needs to be updated	2	1.0%
Wrong specialty reported	21	11.0%

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.
NA = a rate was not calculated for this element.

Table 5-8 presents ACLA's provider access survey after-hours weighted compliance scores by specialty type.

Table 5-8—Provider Access Survey After-Hours Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**46**	**14**	**34.8%**
Primary Care	15	1	6.7%
Pediatrics	10	5	53.3%
OB/GYNs	5	2	46.7%
Endocrinologists	4	1	25.0%
Dermatologists	2	0	16.7%
Neurologists	5	4	80.0%
Orthopedic Surgeons	5	1	40.0%

[1] Compliant providers include providers for which all indicators match between the online provider directory and the information obtained during the survey call to the sampled location.

NAV Audit

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

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG determined that ACLA achieved a *High Confidence* validation rating for all indicators, with the exception of indicators resulting in an *Unable to Validate* designation, which refers to HSAG's overall confidence that ACLA used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Table 5-9 provider type and by urbanicity. LDH established a 100 percent threshold for MCOs when determining requirements met with distance standards. Results that achieved the 100 percent threshold are shaded green. Items marked "NA" indicate provider types for which results were unavailable due to misalignment between instructions within the LDH-provided reporting template, which did not include a requirement to provide results for the applicable indicator.

Table 5-9—ACLA Distance Requirements Met by Percentage of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity	Percentage of Members With Access
Adult PCP (Family/General Practice; Internal Medicine and Physician Extenders*)	Urban	96.8%
	Rural	100%
Pediatrics (Family/General Practice; Internal Medicine and Physician Extenders*)	Urban	89.9%
	Rural	99.7%
Federally Qualified Health Centers (FQHCs)	Urban	84.4%
	Rural	99.3%
Rural Health Clinics (RHCs)	Urban	50.4%
	Rural	99.8%
Acute Inpatient Hospitals	Urban	89.8%
	Rural	99.5%
Laboratory	Urban	98.0%
	Rural	99.6%
Radiology	Urban	97.6%
	Rural	99.6%
Pharmacy	Urban	97.0%
	Rural	100%
Hemodialysis Centers	Urban	88.7%
	Rural	98.0%
Home Health	Urban	NA
	Rural	NA
OB/GYNs (access only for adult female members)	Urban	93.5%
	Rural	85.1%
Allergy/Immunology	Urban	99.1%
	Rural	92.7%
Cardiology	Urban	99.9%
	Rural	100%

Provider Type	Urbanicity	Percentage of Members With Access
Dermatology	Urban	95.9%
	Rural	89.4%
Endocrinology and Metabolism (Adult)	Urban	94.7%
	Rural	89.3%
Endocrinology and Metabolism (Pediatric)	Urban	NA
	Rural	NA
Gastroenterology	Urban	99.9%
	Rural	100%
Hematology/Oncology	Urban	99.9%
	Rural	95.4%
Nephrology	Urban	99.9%
	Rural	97.5%
Neurology (Adult)	Urban	99.9%
	Rural	100%
Neurology (Pediatric)	Urban	NA
	Rural	NA
Ophthalmology	Urban	99.9%
	Rural	100%
Orthopedics (Adult)	Urban	100%
	Rural	100%
Orthopedics (Pediatric)	Urban	NA
	Rural	NA
Otorhinolaryngology/Otolaryngology	Urban	99.9%
	Rural	99.8%
Urology	Urban	99.9%
	Rural	98.5%
Other Specialty Care	Urban	NA
	Rural	NA
Psychiatrists	Urban	94.9%
	Rural	96.1%
Physicians and Licensed Mental Health Professionals (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders	Urban	81.6%
	Rural	58.8%

Provider Type	Urbanicity	Percentage of Members With Access
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders	Urban	80.7%
	Rural	58.8%
Behavioral Health Specialist (Other Specialty Care: APRN-BH specialty, Licensed Psychologist or LCSW)	Urban	98.2%
	Rural	100%
PRTFs, PRTF (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21)	Urban	100%
	Rural	NA
American Society of Addiction Medicine (ASAM) Level 1	Urban	86.4%
	Rural	96.3%
ASAM Level 2.1	Urban	85.1%
	Rural	82.9%
ASAM Level 2 WM	Urban	75.9%
	Rural	71.4%
ASAM Level 3.1 (Adult over age 21)	Urban	87.9%
	Rural	13.9%
ASAM Level 3.1 (Pediatric under age 21)	Urban	88.1%
	Rural	NA
ASAM Level 3.2 WM (Adult over age 21)	Urban	88.5%
	Rural	69.4%
ASAM Level 3.2 WM (Pediatric under age 21)	Urban	69.5%
	Rural	NA
ASAM Level 3.3 (Adult over age 21)	Urban	73.3%
	Rural	56.3%
ASAM Level 3.5 (Adult over age 21)	Urban	91.0%
	Rural	60.7%
ASAM Level 3.5 (Pediatric under age 21)	Urban	98.9%
	Rural	NA
ASAM Level 3.7 (Adult over age 21)	Urban	91.9%
	Rural	95.3%
ASAM Level 3.7 WM	Urban	97.8%
	Rural	95.6%
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	99.9%
	Rural	100%

Provider Type	Urbanicity	Percentage of Members With Access
Mental Health Rehabilitation Agency (Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention—Mental Health Rehabilitation Agency [Legacy MHR], Behavioral Health Rehab Provider Agency [Non-Legacy MHR]; Mental Health Clinics)	Urban	92.2%
	Rural	99.9%

* Physician Extenders: Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services to adults.

HSAG assessed ACLA's results for combined adult PCP and combined pediatrics provider-to-member ratios at the statewide level. The statewide level consists of nine LDH regions, which indicated ACLA's statewide results exceeded LDH-established requirements. Table 5-10displays the statewide combined adult PCP and combined pediatrics provider-to-member ratios.

Table 5-10—ACLA Statewide Combined Adult PCP and Combined Pediatrics Provider-to-Member Ratios

Provider Type	Indicator
Adult PCPs—Physicians Full-Time Employees (FTEs)	Adult PCPs—Physicians (FTEs) (1:1,000 members)
Family/General Practice (that agree to full PCP responsibility)	
Internal Medicine (that agree to full PCP responsibility)	
FQHCs	
RHCs	
Adult PCP Physician Extenders (Equivalent to 0.5 PCP FTE)	Adult PCP Physician Extenders (FTEs) (1:1,000 members equivalent to 0.5 PCP FTE)
Nurse practitioners (that agree to full PCP responsibility)	
Certified nurse mid-wives (that agree to full PCP responsibility)	
Physician assistants linked to a physician group (that agree to full PCP responsibility)	
Pediatric PCPs—Physicians (FTEs)	Pediatric PCPs—Physicians (FTEs) (1:1,000 members)
Family/General Practice (that agree to full PCP responsibility)	
Internal Medicine (that agree to full PCP responsibility)	
FQHCs	
RHCs	

Provider Type	Indicator
Pediatric PCP Physician Extenders (Equivalent to 0.5 PCP FTE)	Pediatric PCP Physician Extenders (FTEs) (1:1,000 members equivalent to 0.5 PCP FTE)
Nurse practitioners (that agree to full PCP responsibility)	
Certified nurse mid-wives (that agree to full PCP responsibility)	
Physician assistants linked to a physician group (that agree to full PCP responsibility)	
Statewide Combined Ratio	
Combined Adult PCP FTEs (1:1,000 adult members)	2.31%
Combined Pediatrics (1:1,000 adult members)	1.07%

HSAG assessed ACLA's results for statewide provider-to-member ratios by specialty provider type and determined that ACLA's statewide results met or exceeded LDH-established requirements. Table 5-11 displays the statewide provider-to-member ratios by provider type and indicator.

Table 5-11—ACLA Statewide Provider-to-Member Ratio by Specialty Provider Type

Specialty Care	Indicator	Statewide Ratio
OB/GYN	1:10,000 (0.01%)	0.30%
Allergy/Immunology	1:100,000 (0.001%)	0.03%
Cardiology	1:20,000 (0.005%)	0.19%
Dermatology	1:40,000 (0.003%)	0.05%
Endocrinology and Metabolism	1:25,000 (0.004%)	0.04%
Gastroenterology	1:30,000 (0.003%)	0.11%
Hematology/Oncology	1:80,000 (0.001%)	0.11%
Nephrology	1:50,000 (0.002%)	0.10%
Neurology	1:35,000 (0.003%)	0.15%
Ophthalmology	1:20,000 (0.005%)	0.11%
Orthopedics	1:15,000 (0.007%)	0.15%
Otorhinolaryngology/Otolaryngology	1:30,000 (0.003%)	0.11%
Urology	1:30,000 (0.003%)	0.08%

HSAG assessed ACLA's results for behavioral health providers to determine the accessibility and availability of appointments and determined that ACLA met all LDH-established performance goals for three reported appointment access standards. Table 5-12 displays the performance measure, threshold, LDH-established performance goal, and achieved compliance rate.

Table 5-12—ACLA Appointment Access Standards Compliance Rate for Behavioral Health

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	98.8%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	98.8%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	98.8%

During the NAV review period, HSAG determined the access/timeliness standards in Table 5-13 were not included in the LDH-required reporting templates, resulting in an *Unable to Validate* validation rating for each associated indicator.

Table 5-13—ACLA Access and Timeliness Standards Unable to Validate

Type of Visit/Admission/Appointment	Access/Timeliness Standard
Urgent Non-Emergency Care	24 hours, 7 days/week within 24 hours of request
Non-Urgent Sick Primary Care	72 hours
Non-Urgent Routine Primary Care	6 weeks
After Hours, by Phone	Answer by live person or call back from a designated medical practitioner within 30 minutes
OB/GYN Care for Pregnant Women:	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High-Risk Pregnancy, Any Trimester	3 days
Family Planning Appointments	1 week
Specialist Appointments	1 month
Scheduled Appointments	Less than a 45-minute wait in office
Psychiatric Inpatient Hospital (Emergency Involuntary)	4 hours
Psychiatric Inpatient Hospital (Involuntary)	24 hours
Psychiatric Inpatient Hospital (Voluntary)	24 hours

Type of Visit/Admission/Appointment	Access/Timeliness Standard
ASAM Levels 3.3, 3.5, and 3.7	10 business days
Residential WM	24 hours when medically necessary
PRTF	20 calendar days

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- ACLA had a detailed Network Development and Management Plan evaluating current and prior network adequacy, identified gaps, and ongoing efforts to improve ACLA's network. ACLA had an engaged provider team working to contract with providers in areas where gaps were identified and exploring alternative options such as telehealth to improve access to care. **[Quality, Timeliness, and Access]**
- ACLA had established robust processes to maintain accuracy and completeness of provider information through weekly and monthly reconciliation efforts, ongoing provider outreach and verification of information, and audit processes. **[Quality, Timeliness, and Access]**
- No strengths were identified in the PDV activity, as all indicators had match rates below 90 percent.
- Of the cases that offered an appointment date in the provider access survey, 100 percent of routine pediatric cases offered an appointment within the compliance standard. **[Timeliness and Access]**

For ACLA, the following opportunities for improvement were identified:

- No specific opportunities were identified related to the systems, management processes, or data integration ACLA had in place to inform network adequacy standard and indicator calculation and reporting. **[Quality, Timeliness, and Access]**
- Acceptance of Louisiana Medicaid was inaccurate with 68.0 percent of providers in the PDV and 58.6 percent of locations in the provider access survey accepting Louisiana Medicaid. **[Quality and Access]**
- Acceptance of ACLA was inaccurate with 70.0 percent of providers in the PDV and 60.0 percent of locations in the provider access survey accepting ACLA. **[Quality and Access]**
- Overall, only 76.0 percent of providers in the PDV and 72.1 percent of locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**
- Overall, acceptance of new patients was relatively low with 75.3 percent of providers in the PDV and 52.1 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 80.8 percent of PDV locations and 45.7 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**

- Of the cases that offered an appointment, 80.0 percent of routine primary care and non-urgent sick primary care cases, 75.0 percent of dermatology cases, 66.7 percent of non-urgent sick pediatric cases, 50.0 percent of neurologist cases, 33.3 percent of OB/GYN cases, and 0.0 percent of endocrinologist cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by survey type with an overall compliance score of 50.8 percent for the PDV, 43.8 percent for the provider access survey, and 34.8 percent for the after-hours provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with internal medicine/family medicine having the lowest compliance score at 40.7 percent and OB/GYN having the highest compliance score at 64.0 percent for the PDV. For the provider access survey, primary care exhibited the lowest compliance score at 29.4 percent and dermatologists exhibited the highest compliance score at 61.1 percent. While primary care exhibited the lowest compliance score at 6.7 percent and neurologists exhibited the highest compliance score at 80.0 percent for the after-hours provider access survey. **[Quality and Access]**

For ACLA, the following recommendations were identified:

- LDH should provide ACLA with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which ACLA will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). **[Quality and Access]**
- In addition to updating provider information, ACLA should conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent. **[Quality and Access]**
- ACLA should consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care. **[Timeliness and Access]**

Methodology

Objectives

The purpose of NAV activities is to evaluate the sufficiency of the provider network as reported by the MCO, ensure the sufficiency of the network to provide adequate access to all services covered under the contract for all members, and provide recommendations to address network deficiencies.
In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, and PAHPs, collectively referred to as "MCEs," are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

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

Technical Methods of Data Collection

In February 2023, CMS released updates to the CMS EQR protocols, including the newly developed NAV protocol. As established in the 2016 final rule, states must begin conducting the NAV activity at 42 CFR §438.358(b)(1)(iv) no later than one year from the issuance of the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[5-1] Therefore, in February 2024, HSAG began conducting NAV activities in accordance with the CMS EQR Protocol 4 and will report results in the EQR technical report due April 30, 2025.

Provider Directory Validation

HSAG conducted PDV reviews from July 2023 through November 2023. To conduct the NAV analysis, HSAG utilized the MCOs' online provider directories to locate and extract provider data elements. Trained interviewers collected survey responses using a standardized script to validate survey indicators pertaining to provider data accuracy, such as telephone number, address, provider specialty, provider

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 17, 2024.

affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance.

Provider Access Survey

HSAG conducted provider access surveys in September 2023 and November to December 2023. To conduct the NAV analysis, each MCO used the data request document prepared by HSAG to identify providers potentially eligible for survey inclusion, and to submit provider data files used to populate its online provider directory to HSAG. At a minimum, the data elements requested for each provider included: provider name, Medicaid identification (ID), National Provider Identification (NPI) number, provider specialty, physical (practice) address, telephone number, provider taxonomy code, and whether the provider accepted new patients.

Upon receipt of the data files, HSAG assessed the data to ensure alignment with the requested data file format, data field contents, and logical consistency between data elements. HSAG also assessed the distribution of provider specialty data values present in each MCO's data to determine which data values attributed to each provider domain.

NAV Audit

HSAG collected network adequacy data from the MCOs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR Protocol 4.

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

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

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

Description of Data Obtained

HSAG, with approval from LDH, conducted the following network adequacy monitoring tasks during CY 2023:

1. PDV, to validate the MCOs' online provider directories to ensure members have appropriate access to provider information. HSAG utilized the MCOs' online provider directories to locate and extract provider data elements required to conduct the survey component of the PDV activity.
2. Provider access survey, to determine the accuracy of the managed care network information supplied to Healthy Louisiana members using the MCOs' provider data files and to ensure that Louisiana provider networks are following the established LDH standard for office-hour appointments. HSAG utilized the MCOs' provider data files used to populate their online provider directories to conduct the survey component of the provider access survey activity.
3. HSAG prepared a document request packet that was submitted to each MCO outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCO's IS and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the MCOs to conduct the NAV audits:
   - IS data from the ISCAT
   - Network adequacy logic for calculation of network adequacy indicators
   - Network adequacy data files
   - Network adequacy monitoring data
   - Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Data Were Aggregated and Analyzed

Provider Directory Validation

For each sampled case, HSAG compared the MCOs' provider directory values to the information obtained via the survey call for the following list of indicators. All items must match exactly, except for common United States Postal Service (USPS) standard abbreviations and naming conventions (e.g., E and East or 1st and First).

- Telephone number
- Address
- Office affiliation with the sampled provider
- Accuracy of provider specialty

- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance

HSAG used the following validation responses to assess each indicator:

- Yes, the information matched between the online provider directory and the survey call.
- No, the information did not match between the online provider directory and the survey call.

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-14 were used to calculate the weight of each noncompliance survey outcome.

Table 5-14—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-15—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-14. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75.

Provider Access Survey

Using a survey script approved by LDH, HSAG validated the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Accuracy of provider specialty
- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance
- Sampled provider at location
- Appointment availability

Using the results of the survey, HSAG calculated a compliance score for each MCO. The criteria in Table 5-16 were used to calculate the weight of each noncompliance survey outcome.

Table 5-16—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-17—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-16. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent.

NAV Audit

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

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

How Conclusions Were Drawn

Provider Directory Validation/Provider Access Survey

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Healthy Louisiana member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-18.

Table 5-18—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
PDV	✓		✓
Provider Access Survey	✓	✓	✓

NAV Audit

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 5-19.

Table 5-19—Validation Score Calculation

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

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 5-20 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-20—Indicator-Level Validation Rating Categories

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

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

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

impact was unable to be quantified and therefore was determined to have the potential for significant bias.

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

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-21.

Table 5-21—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Provider: Enrollee Ratio	✓	✓	✓
Distance	✓	✓	✓
Access and Timeliness Standards	✓	✓	✓

6. Consumer Surveys: CAHPS-A and CAHPS-C

Results

Table 6-1 presents ACLA's 2022, 2023, and 2024 (review period) adult achievement scores.

Table 6-1—Adult Achievement Scores

Measure	2022	2023	2024
Rating of Health Plan	81.21%	81.21%	76.47%
Rating of All Health Care	82.30%	82.30%	72.79% ▼
Rating of Personal Doctor	85.77%	85.77%	82.82%
Rating of Specialist Seen Most Often	79.72%	79.72%	NA
Getting Needed Care	82.28%	82.28%	79.75%
Getting Care Quickly	86.39%	86.39%	80.82%
How Well Doctors Communicate	93.41%	93.41%	94.19%
Customer Service	95.76%	95.76%	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 NCQA national average.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 NCQA national average.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Table 6-2 presents ACLA's 2022, 2023, and 2024 (review period) general child achievement scores.

Table 6-2—General Child Achievement Scores

Measure	2022	2023	2024
Rating of Health Plan	86.33%	86.33%	85.96%
Rating of All Health Care	86.57%	86.57%	86.11%
Rating of Personal Doctor	91.85%	91.85%	91.95%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	86.29%	86.29%	NA
Getting Care Quickly	90.10%	90.10%	NA
How Well Doctors Communicate	93.08%	93.08%	93.62%
Customer Service	NA	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 NCQA national average.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 NCQA national average.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- For the adult and general child populations, ACLA's scores were not statistically significantly higher in 2024 than 2023 nor statistically significantly higher than the 2024 NCQA national averages on any of the measures; therefore, no strengths were identified.

For ACLA, the following opportunities for improvement were identified:

- For the adult population, ACLA's 2024 adult achievement score was statistically significantly lower than in 2023 for *Rating of All Health Care*. **[Quality]**
- For the general child population, ACLA's scores were not statistically significantly lower in 2024 than 2023 nor statistically significantly lower than the 2024 NCQA national averages on any of the measures; therefore, no opportunities for improvement were identified.

For ACLA, the following recommendation was identified:

- HSAG recommends ACLA conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need. **[Quality]**

Methodology

Objectives

The CAHPS activity assesses adult members' and parents'/caretakers' of child members experiences with an MCO and the quality of care that they/their children receive. The goal of the CAHPS surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) and mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents). In addition, some MCOs had an option for members to complete the survey in Spanish and Chinese. Adult members and parents/caretakers of child members completed the surveys from February through May 2024, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (39 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed members' experiences with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite measures.[6-1] The global ratings reflected patients' overall experiences with their personal doctor, specialist, MCO, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, HSAG calculated the percentage of respondents who chose a positive experience rating (a response value of 8, 9, or 10 on a scale of 0 to 10). For each of the four composite measures, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measures was a response of "Usually" or "Always."

[6-1] For this report, the 2024 Child Medicaid CAHPS results presented are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

For this report, HSAG did not include results for a CAHPS measure if the NCQA minimum reporting threshold of 100 respondents was not met. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to the 2024 NCQA CAHPS adult and general child Medicaid national averages.[6-2]

Description of Data Obtained

The CAHPS survey asks adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The MCOs contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experiences with their MCO during the last six months of the measurement period (i.e., July through December 2023).

The MCOs' CAHPS vendors administered the surveys from February to May 2024. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[6-3] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, did not meet the eligible population criteria, had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2024 achievement scores were compared to their corresponding 2023 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2024 achievement scores and the 2023 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2024 than 2023 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2024 than 2023 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was not denoted with a triangle.

Additionally, HSAG compared MCO scores to the NCQA national averages to determine if there were any statistically significant differences. An MCO that performed statistically significantly higher than the 2024 NCQA national average was denoted with a green upward arrow (↑).[6-4] Conversely, an MCO

6-2 National data were obtained from NCQA's 2024 Quality Compass.

6-3 A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 10, 19, 23, and 28. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for child Medicaid: questions 3, 25, 40, 44, and 49.

6-4 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

that performed statistically significantly lower than the 2024 NCQA national average was denoted with a red downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2024 NCQA national average was not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2024 survey results to the 2024 NCQA national averages to determine if there were any statistically significant differences. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains. This assignment to the domains is depicted in Table 6-3.

Table 6-3—Assignment of CAHPS Survey Measure Activities to the Quality, Timeliness, and Access Domains

CAHPS Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

7. Behavioral Health Member Satisfaction Survey

Results

Table 7-1 presents the 2023 and 2024 (review period) adult achievement scores for ACLA and the Healthy Louisiana SWA.

Table 7-1—Adult Achievement Scores for ACLA

Measure	2023	2024	Healthy Louisiana SWA
Rating of Health Plan	58.93%	54.14%	56.43%
How Well People Communicate	92.44%	91.36%	92.65%
Cultural Competency	90.00%+	91.67%+	82.85%+
Helped by Counseling or Treatment	73.65%	74.84%	69.38%
Treatment or Counseling Convenience	90.42%	89.87%	88.46%
Getting Needed Treatment	81.33%	80.77%	81.83%
Help Finding Counseling or Treatment	34.38%+	73.53%+▲	52.90%
Customer Service	73.08%+	71.43%+	71.32%
Helped by Crisis Response Services	78.57%+	80.00%+	75.17%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 Healthy Louisiana SWA.*

↓ *Indicates the 2024 score is statistically significantly lower than the 2024 Healthy Louisiana SWA.*

▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*

▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Table 7-2 presents the 2023 and 2024 (review period) child achievement scores for ACLA and the Healthy Louisiana SWA.

Table 7-2—Child Achievement Scores

Measure	2023	2024	Healthy Louisiana SWA
Rating of Health Plan	64.29%+	59.48%	65.18%
How Well People Communicate	93.49%+	92.13%	90.74%
Cultural Competency	100.00%+	100.00%+	90.17%+
Helped by Counseling or Treatment	70.83%+	60.68%	56.92%
Treatment or Counseling Convenience	91.67%+	87.93%	86.12%
Getting Needed Treatment	85.92%+	79.13%	77.13%
Help Finding Counseling or Treatment	30.77%+	47.83%+	46.93%+
Customer Service	71.43%+	75.00%+	59.54%+

Measure	2023	2024	Healthy Louisiana SWA
Getting Professional Help	87.14%+	89.66%	85.72%
Help to Manage Condition	91.55%+	81.20%▼	83.70%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 Healthy Louisiana SWA.*

↓ *Indicates the 2024 score is statistically significantly lower than the 2024 Healthy Louisiana SWA.*

▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*

▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- For the adult population, ACLA's 2024 score was statistically significantly higher than the 2023 score for *Help Finding Counseling or Treatment.* **[Quality and Access]**
- For the child population, ACLA did not score statistically significantly higher than the 2024 Healthy Louisiana SWA or statistically significantly higher in 2024 than 2023 on any of the measures; therefore, no strengths were identified.

For ACLA, the following opportunities for improvement were identified:

- For the adult population, ACLA's 2024 scores were not statistically significantly lower than the 2024 Healthy Louisiana SWA nor statistically significantly lower in 2024 than 2023 on any of the measures; therefore, no opportunities for improvement were identified.
- For the child population, ACLA's 2024 score was statistically significantly lower than the 2023 score for *Help to Manage Condition*. **[Quality]**

For ACLA, the following recommendations were identified:

- HSAG recommends that ACLA conduct root cause analyses or focus studies to determine why parents/caretakers of child members perceive an overall lack of quality of care and services, such as poor communication or services, or a lack of quality of care from their providers or health plan staff. ACLA could consider whether there are disparities within its population that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, ACLA should implement appropriate interventions to improve the performance related to the care members need. **[Quality]**

Methodology

Objectives

The primary objective of this activity is to gather direct feedback from Healthy Louisiana adult members and parents/caretakers of child members who received behavioral health services regarding their experiences and the quality of the services they received. The survey covers topics that are important to members, such as the communication skills of people they saw for counseling or treatment and the accessibility of behavioral health services. This feedback will aid in improving overall experiences of adults and parents/caretakers of child members who receive behavioral health services.

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom behavioral health member satisfaction survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from June to August 2024.

The adult and child behavioral health member satisfaction survey included one global measure question, one composite measure, and 11 individual item measures. The global measure (also referred to as global rating) reflects overall member experience with the MCO. The composite measure is a set of questions grouped together to address a specific aspect of care (i.e., *How Well People Communicate)*. The individual item measures are individual questions that look at different areas of care (e.g., *Cultural Competency* or *Helped by Counseling or Treatment*).

For the global rating, HSAG calculated the percentage of respondents who chose a positive experience rating (i.e., a response of 9 or 10 on a scale of 0 to 10). For the composite measure, HSAG calculated the percentage of respondents who chose a positive response. The composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measure was a response of "Usually" or "Always." For the individual item measures, HSAG calculated the percentage of respondents who chose a positive response (i.e., "Usually/Always," "Yes," "A lot," or "Not a problem").

For this report, HSAG included results for a measure even when there were less than 100 respondents. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. HSAG used a cross (+) to denote scores with fewer than 100 respondents.

Description of Data Obtained

The behavioral health member satisfaction survey asked adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with behavioral health services. HSAG requested sample frame data files from each MCO that included the following information related to each member of the eligible population: name, gender, date of birth, mailing address, telephone number, primary language, race, and ethnicity. HSAG utilized information received in the sample frame data files to conduct the behavioral health member satisfaction survey.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2024 achievement scores were compared to their corresponding 2023 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2024 achievement scores and the 2023 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2024 than 2023 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2024 than 2023 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was not denoted with a triangle.

Additionally, HSAG compared the MCO-specific results to the total MCO program average to determine if the results were significantly different. The total MCO program results were weighted based on the eligible population included in each MCO. An MCO that performed statistically significantly higher than the program average was denoted with an upward black arrow (↑). Conversely, an MCO that performed statistically significantly lower than the program average was denoted with a downward black arrow (↓). An MCO that did not perform statistically significantly different than the program average was not denoted with an arrow. Comparisons to national data could not be performed given the custom nature of the survey instruments administered.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care and services provided by the MCOs, HSAG assigned the measures evaluated in the behavioral health member satisfaction survey to one or more of these three domains. This assignment to domains is shown in Table 7-3.

Table 7-3—Assignment of Behavioral Health Member Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
How Well People Communicate	✓		
Cultural Competency	✓		

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Helped by Counseling or Treatment	✓		
Treatment or Counseling Convenience			✓
Getting Counseling or Treatment Quickly	✓	✓	
Getting Needed Treatment	✓		✓
Barriers to Counseling or Treatment	✓		✓
Help Finding Counseling or Treatment	✓		✓
Customer Service	✓		
Crisis Response Services Used			✓
Receipt of Crisis Response Services			✓
Helped by Crisis Response Services	✓		
Getting Professional Help	✓		✓
Help to Manage Condition	✓		

8. Health Disparities Focus Study

While the 2023 (review period) Annual Health Disparities Focus Study included MCO-specific findings, the overall results and conclusions of this study are not MCO-specific. Therefore, please refer to the annual MCO aggregate technical report for high-level statewide findings from the 2023 Annual Health Disparities Focus Study.

Methodology

The Louisiana Medicaid Managed Care Quality Strategy outlines that one of LDH's objectives is to advance health equity and address social determinants of health. In an effort to measure and address health disparities, LDH and HSAG partnered to perform the 2023 Annual Health Disparities Focus Study. For the 2023 Annual Health Disparities Focus Study, HSAG identified statewide and MCO-specific disparities based on race, ethnicity, and geography using calendar year (CY) 2022 data.

Technical Methods of Data Collection

HSAG used the MCO-provided *Race Ethnicity and Rural Urban Stratification* Microsoft Excel spreadsheets to identify disparities based on race, ethnicity, and geography for select HEDIS and non-HEDIS indicators. HSAG used the MY 2022 HEDIS IDSS data files and MY 2022 CAHPS data files to identify disparities for select HEDIS and CAHPS indicators based on race and ethnicity.

Description of Data Obtained

Table 8-1 displays all measure indicators, data sources, and the applicable stratifications that were assessed for health disparities. HSAG assigned each indicator to one of the following domains based on the type of care or health status being measured: Member Experience With Health Plan and Providers, Getting Care, Chronic Conditions, Children's Health, Women's Health, and Behavioral Health.

Table 8-1—Measure Indicators, Data Sources, and Stratifications Organized by Domains

Measure Indicator	Data Source	Stratification
Member Experience With Health Plan and Providers		
Rating of Health Plan—Adult (RHP–Adult) and *Child* (RHP–Child)	CAHPS Data	Race and Ethnicity
Rating of All Health Care—Adult (RHC–Adult) and *Child* (RHC–Child)		
Customer Service—Adult (CS–Adult) and *Child* (CS–Child)		
How Well Doctors Communicate—Adult (HWD–Adult) and *Child* (HWD–Child)		

Measure Indicator	Data Source	Stratification
Rating of Personal Doctor—Adult (RPD–Adult) and *Child* (RPD–Child)		
Rating of Specialist Seen Most Often—Adult (RSP–Adult) and *Child* (RSP–Child)		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit (MSC–Quit), *Discussing Cessation Medications* (MSC–Meds), and *Discussing Cessation Strategies* (MSC–Strategies)		
Getting Care		
Getting Needed Care—Adult (GNC–Adult) and *Child* (GNC–Child)	CAHPS Data	Race and Ethnicity
Getting Care Quickly—Adult (GCQ–Adult) and *Child* (GCQ–Child)		
Flu Vaccinations for Adults (FVA)		
Colorectal Cancer Screening (COL)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Chronic Conditions		
Controlling High Blood Pressure (CBP)^	HEDIS IDSS	Race and Ethnicity
HbA1c Control for Patients With Diabetes^—HbA1c Control (<8.0 Percent) (HBD–8) and *HbA1c Poor Control (>9.0 Percent)* (HBD–9)*	HEDIS IDSS	Race and Ethnicity
Human Immunodeficiency Virus (HIV) Viral Load Suppression (HVL)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Children's Health		
Child and Adolescent Well-Care Visits (WCV)	HEDIS IDSS	Race and Ethnicity
Childhood Immunization Status—Combination 3 (CIS–3)^	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Immunizations for Adolescents—Combination 2 (IMA–2)^		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)		
Low Birthweight Births (LBW)*		

Measure Indicator	Data Source	Stratification
Women's Health		
Cervical Cancer Screening (CCS)^	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Contraceptive Care—Postpartum Care—Long-Acting Reversible Contraception (LARC)—3 Days—Ages 21–44 (CCP–LARC3–2144) and *90 Days—Ages 21–44* (CCP–LARC90–2144)		
Contraceptive Care—Postpartum Care—Most or Moderately Effective Contraception (MMEC)—3 Days—Ages 21–44 (CCP–MMEC3–2144) and *90 Days—Ages 21–44* (CCP–MMEC90–2144)		
Prenatal and Postpartum Care^*—Timeliness of Prenatal Care* (PPC–Prenatal) and *Postpartum Care* (PPC–Postpartum)	HEDIS IDSS	Race and Ethnicity
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up (FUH–30)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM–30)		
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up (FUA–30)		

^ indicates a measure indictor that can be calculated using the hybrid methodology.
** indicates that a lower rate is better for this measure indicator.*

How Data Were Aggregated and Analyzed

Statewide Rate Calculations

HSAG calculated stratified rates for all HEDIS, non-HEDIS, and CAHPS measure indicators listed in Table 8-1. For the HEDIS and non-HEDIS measure indicators reported through IDSS files (HEDIS only) and the *Race Ethnicity and Rural Urban Stratification* Excel spreadsheets (HEDIS and non-HEDIS), HSAG extracted the stratified MCO-reported numerators, denominators, and rates provided in the reporting templates.

Additionally, HSAG used the survey responses provided in the CAHPS data files to calculate the stratified MCO-specific CAHPS rates. Each member was assigned a race and ethnicity based on their survey responses. To calculate a rate for a CAHPS measure indicator, HSAG converted each individual question by assigning the positive responses (i.e., "9/10," "Usually/Always," and "Yes" where applicable) to a "1" for each individual question, as described in *HEDIS MY 2022 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of "0." HSAG then calculated the percentage of respondents with a positive response (i.e., a "1"). For composite measures (i.e., CS, GNC, GCQ, and HWD), HSAG calculated the positive rating by taking the average percentage of positive ratings for each question within the composite. An MCO-specific

stratified rate was calculated by determining the percentage of respondents who gave a positive response for each race and ethnicity. For the Effectiveness of Care CAHPS measure indicators (i.e., MSC and FVA), HSAG identified the denominator and numerator in alignment with the *HEDIS MY 2022 Volume 2: Technical Specifications for Health Plans*.

HSAG then calculated a statewide aggregate for each HEDIS, non-HEDIS, and CAHPS measure indicator by summing the numerators and denominators reported by each MCO. For measure indicator rates that were reported using the hybrid methodology (please see Table 8-1 for measure indicators with a hybrid option), rates were based on a sample selected from the measure indicator's eligible population. For the *Immunizations for Adolescents—Combination 2* (IMA–2) indicator one MCO reported the hybrid measure using the administrative option (i.e., the rate is not based on a sample of cases). Given that one MCO's eligible population was larger than 411, HSAG transformed the administrative denominator and numerator to replicate a sample of 411 members in order to limit the overrepresentation of the MCO's members toward the SWA. To do this, HSAG first calculated a transformed weight by taking 411 divided by the eligible population of the total rate. HSAG then multiplied each stratified numerator and denominator by the transformed weight to calculate the transformed numerator and denominator. This method allowed for each stratification in the transformed rate to maintain the same proportion of the total population as the original rate, while also having the same performance (i.e., the transformed rate is equal to the original rate). Table 8-2 provides an example of how the transformed rates were calculated.

Table 8-2—Transformed Rate Calculation

Race Category	Eligible Population (A)	Numerator (B)	Rate (C)	Transformed Weight (D) 411/A	Transformed Denominator (E) A*D	Transformed Numerator (F) B*D	Transformed Rate (G) F/E
Total	5,000	2,500	50.00%	0.0822	411.0000	205.5000	50.00%
White	1,700	800	47.06%		139.7400	65.7600	47.06%
Black or African American	2,100	1,200	57.14%		172.6200	98.6400	57.14%
American Indian or Alaska Native	25	13	52.00%		2.0550	1.0686	52.00%
Asian	30	16	53.33%		2.4660	1.3152	53.33%
Native Hawaiian or Other Pacific Islander	10	6	60.00%		0.8220	0.4932	60.00%
Other	800	401	50.13%		65.7600	32.9622	50.13%
Unknown	335	170	50.75%		27.5370	13.9740	50.75%

Identifying Health Disparities

For the measure indicators listed in Table 8-1, HSAG identified statewide and MCO-specific disparities based on race, ethnicity, and geography, where applicable (see Table 8-1 for which stratifications apply to each measure indicator). Table 8-3 and Table 8-4 display the race and ethnicity categories that were included in each of the MCO-provided *Race Ethnicity and Rural Urban Stratification* Excel spreadsheets, HEDIS IDSS, and CAHPS data files, along with individual racial and ethnic groups that comprise each category. Given the variation in race and ethnicity categories across data files, HSAG included the individual racial and ethnic groups from each data source in the "Groups Included" columns in Table 8-3 and Table 8-4; however, the race and ethnicity categories listed were used in the analysis, where applicable.

Table 8-3—Race Categories

Race Category	Groups Included
White*	White
Black or African American	Black or African American, Black or African-American
American Indian or Alaska Native	American Indian or Alaska Native, American Indian and Alaska Native
Asian	Asian
Native Hawaiian or Other Pacific Islander	Native Hawaiian and Other Pacific Islander, Native Hawaiian or Other Pacific Islander
Other	Other, Some Other Race, Two or More Races
Unknown^	Unknown, Asked but No Answer

** indicates reference group for the identification of racial disparities.*
^ indicates for the CAHPS measure indicators, "Unknown" includes members who did not provide a response.

Table 8-4—Ethnicity Categories

Ethnicity Category	Groups Included
Hispanic/Latino	Hispanic/Latino, Hispanic or Latino
Non-Hispanic/Latino*	Non-Hispanic/Latino, Not Hispanic/Latino, Not Hispanic or Latino
Unknown^	Unknown Ethnicity, Declined Ethnicity, Asked but No Answer

** indicates reference group for the identification of ethnic disparities.*
^ indicates for the CAHPS measure indicators, "Unknown" includes members who did not provide a response.

Table 8-5 displays the geography categories and the parishes included in each.

Table 8-5—Geography Categories and Parishes

Geography	Parishes
Urban*	Acadia, Ascension, Bossier, Caddo, Calcasieu, East Baton Rouge, Jefferson, Lafayette, Lafourche, Livingston, Orleans, Ouachita, Plaquemines, Rapides, St. Bernard, St. Charles, St. James, St. John, St. Landry, St. Martin, St. Tammany, Terrebonne, Webster, West Baton Rouge
Rural	Allen, Assumption, Avoyelles, Beauregard, Bienville, Caldwell, Cameron, Catahoula, Claiborne, Concordia, DeSoto, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson Davis, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Pointe Coupee, Red River, Richland, Sabine, St. Helena, St. Mary, Tangipahoa, Tensas, Union, Vermilion, Vernon, Washington, West Carroll, West Feliciana, Winn
Unknown	Unknown

** indicates reference group for the identification of disparities.*

A disparity was identified if the relative difference between the demographic group (the group of interest) and the reference group was more than 10 percent. For rates for which a higher rate indicates better performance, the relative difference was calculated using the following equation:

$$Relative\ Difference = \frac{(Group\ of\ Interest\ Performance Rate - Reference\ Group\ Performance Rate)}{Reference Group\ Performance Rate}$$

For example, for identifying racial disparities, if the rate of eligible members receiving well-child visits for the White group was 65.0 percent and the rate for the Black or African American group was 45.0 percent, the rate for the Black or African American group (the group of interest) was below the rate for the White group (the reference group) by more than a 30 percent relative difference, indicating a disparity. This is shown in the equation below:

$$-30.8\% = \frac{(45.0\% - 65.0\%)}{65.0\%}$$

For measure indicators for which a lower rate indicates better performance,[8-1] the relative difference was calculated using the following equation:

$$Relative\ Difference = \frac{(Reference\ Group\ Performance Rate - Group\ of\ Interest\ Performance Rate)}{Reference Group\ Performance Rate}$$

For example, for identifying racial disparities, if the low birthweight rate for the Black or African American group was 13.0 percent and the rate for the White group was 9.0 percent, the rate for the Black or African American group (the group of interest) was above the rate for the White group (the reference group) by more than a 40 percent relative difference, indicating a disparity. This is shown in the equation below:

$$-44.4\% = \frac{(9.0\% - 13.0\%)}{9.0\%}$$

Disparities were categorized by the following color system:

1. indicates the rate for the group of interest was better than the reference group (i.e., the relative difference was more than 10 percent).
2. indicates the rate for the group of interest was worse than the reference group (i.e., the relative difference was less than −10 percent).
3. White cells indicate that a disparity was not identified.

How Conclusions Were Drawn

To draw conclusions about identified statewide and MCO-specific health disparities, HSAG first compared disparities identified for Louisiana Medicaid to national disparities and compared rates to the 2023 NCQA Quality Compass®,[8-2] national Medicaid HMO percentiles or the CMS Federal Fiscal Year (FFY) 2022 Child and Adult Health Care Quality Measures data,[8-3] where applicable. HSAG then assessed if specific measure indicators, domains, or demographic groups had disparities consistently identified.

[8-1] Please refer to those measure indicators in Table 8-1 marked with an asterisk (*) for measure indicators for which a lower rate indicates better performance.
[8-2] Quality Compass® is a registered trademark of the NCQA.
[8-3] Data. Medicaid.gov. 2022 Child and Adult Health Care Quality Measures. Available at: https://data.medicaid.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6. Accessed on: Dec 17, 2024.

9. Case Management Performance Evaluation

Introduction

States may direct their EQROs to conduct focus studies for QI, administrative, legislative, or other purposes. Focus studies may examine clinical or nonclinical aspects of care provided by MCOs and assess quality of care at a specific point in time. LDH contracted with HSAG to conduct a focused CMPE to evaluate the MCO's compliance with the case management provisions of its contract with LDH and determine the effectiveness of case management activities.

Activities Conducted During SFY 2024

During SFY 2024, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG conducted the focus study in accordance with the CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[9-1]

During SFY 2024, HSAG completed two CMPE reviews. Each review focused on specific populations of enrollees with special health care needs (SHCN):

- CY 2023 review (conducted from October through December 2023 [review period]): Enrollees with a classification of SHCN-Medical ("SHCN-MED"), SHCN-Behavioral Health ("SHCN-BH"), or "SHCN-BOTH" (composed of both MED and BH cases).
- CY 2024 review (conducted from March through April 2024 [review period]): Enrollees with a classification of SHCN-Department of Justice at-risk ("SHCN-DOJ-AR").

[9-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 17, 2024.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- The results of both reviews demonstrated that no findings resulted in concerns regarding an enrollee's health, safety, or welfare. **[Quality]**
- For the CY 2023 review, two of three domains demonstrated overall performance greater than 80 percent. **[Quality]**
- The results of both reviews demonstrated that the health plan was successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans. **[Quality, Timeliness, and Access]**

For ACLA, the following opportunities for improvement were identified:

- Both reviews determined that the health plan demonstrated opportunity for improvement with elements related to ongoing scheduled case management activities. **[Timeliness]**

For ACLA, the following recommendations were identified:

- The health plan should evaluate its oversight processes to ensure that case managers and supervisory staff have tools to effectively manage activities that occur regularly. Case management system flags, queues, or reports that remind staff members of upcoming contact requirements (i.e., reassessments, plan of care [POC] updates, enrollee contacts) should be considered; leadership audits may need to focus on these time-sensitive elements. The health plan reported improvement on internal auditing and oversight processes, with weekly leadership reviews and communication to case managers. **[Quality and Timeliness]**
- The MCO should evaluate options in its care management system to ensure the POC is person-centered, identifies risks and barriers and formal and informal supports, and incorporates the behavioral health treatment plan. The MCO should train case management staff to utilize system drop-downs and/or document additional narrative to enhance the POC, as well as ensure that all POC elements are addressed. **[Quality]**
- Due to the high volume of Tier 1 enrollees, the health plan should consider reviewing enrollee tier assignments to ensure that case management acuity determinations are documented and that tier assignments are appropriate for the level of need of each enrollee. **[Quality]**
- The health plan should evaluate its unable to reach process to ensure alignment with LDH's expectations for outreach. **[Quality]**
- The health plan should evaluate its multidisciplinary (MCT) process to ensure MCT meetings are conducted at regular intervals, or that an enrollee's refusal of MCT meetings is documented. The health plan should also review its MCT process to ensure that all MCT participants are invited to attend meetings and that declinations of attendance are documented. **[Timeliness]**

Methodology

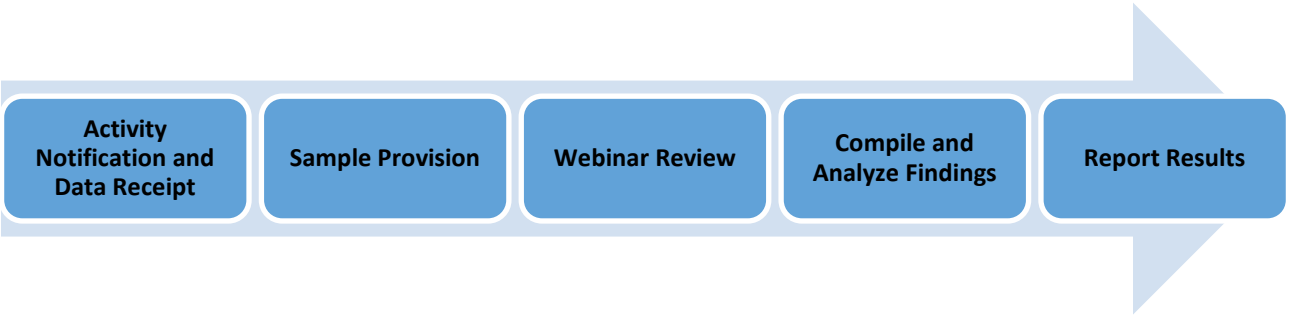
Objectives

LDH requires the Healthy Louisiana MCO reporting of data on case management services to determine the number of individuals, the types of conditions, and the impact that case management services have on enrollees receiving those services. LDH established case management requirements to ensure that the services provided to enrollees with SHCN are consistent with professionally recognized standards of care. To assess MCO compliance with case management elements, LDH requested that HSAG evaluate the MCOs' compliance with the case management provisions of their contracts with LDH, including the rates of engagement in case management; the specific services offered to enrollees receiving case management; and the effectiveness of case management in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

HSAG's case management PE review tool comprehensively addressed the services and supports that are necessary to meet enrollees' needs. The tool included elements for review of case management documentation and enrollee care plans to ensure that they are consistent with a person-centered approach to care planning and service delivery and that outcomes are being achieved or progress is being made toward their achievement. The CMPE review tool included MCO contract requirements, evaluation criteria of those requirements, and reviewer determinations of performance.

Review Process

HSAG's case management review process included five activities:



Activity 1: Activity Notification and Data Receipt

To initiate the case management review, HSAG conducted an activity notification webinar for the MCOs. During the webinar, HSAG provided information about the activity and expectations for MCO participation, including provision of data. HSAG requested the *LA PQ039 Case Management* report from each MCO.

Table 9-1—Activity 1: Activity Notification and Data Receipt

For this step,	HSAG will…
Step 1:	**Notify the MCOs of the review.**
	HSAG hosted a webinar to introduce the activity to the MCOs. The MCOs were provided a timeline, review tools, and a question and answer (Q&A) document post-webinar. HSAG provided assistance to all MCOs prior to the review, including clear instructions regarding the scope of the review, timeline and logistics of the webinar review, identification of expected review participants, and any other expectations or responsibilities.
Step 2:	**Receive data universes from the MCOs.**
	HSAG reviewed the data received from the MCOs for completeness.

Activity 2: Sample Provision

Upon receipt of each MCO's *LA PQ039 Case Management* report, HSAG reviewed the data to ensure completeness for sample selection. To be included in the sample, the enrollee must have met the following criteria:

For the CY 2023 review:

- Have a classification of "SHCN-MED," "SHCN-BH," or "SHCN-BOTH." HSAG identified these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or before June 1, 2023. HSAG identified these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of at least three months. HSAG identified these enrollees by utilizing data from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.

For the CY 2024 review:

- Have a classification of "SHCN-DOJ-AR." HSAG identified these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Identified by the MCOs as "accepted" in the "enrollment offer result" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or after October 1, 2023. HSAG identified these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of at least three months. HSAG identified these enrollees by utilizing data from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.

If the criteria above did not allow for the sample size to be achieved, HSAG conducted a second stage approach to include enrollees meeting the following criteria:

- Have a classification of "SHCN-DOJ-AR." HSAG will identify these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Identified by the MCOs as "enrolled in case management" in the "assessment result" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or after October 1, 2023. HSAG will identify these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of less than 90 days as identified from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.
- Have a completed assessment and plan of care. HSAG will identify these enrollees by the "date of assessment" and "date plan of care completed" fields provided in the *LA PQ039 Case Management* report.

Enrollees who were identified by the MCOs for case management but not enrolled were excluded from the sample.

In future review years, HSAG will collaborate with LDH to determine any changes to the sampling criteria, including exclusions such as enrollees who were selected for the review the year prior.

Based on the inclusion criteria, HSAG generated a random sample of enrollees for each MCO, which included a 10 percent oversample to account for exclusions or substitutions. HSAG provided each MCO with its sample 10 business days prior to the webinar review. The MCO was given five business days to provide HSAG with any requests for exclusions or substitutions. If the oversample was not large enough to obtain the necessary sample size, HSAG selected additional random samples to fulfill the sample size. The final sample of cases were confirmed with the MCO no later than three business days prior to the webinar review.

Table 9-2—Activity 2: Sample Provision

For this step,	HSAG will…
Step 1:	**Identify enrollees for inclusion in the sample.**
	HSAG utilized the data provided in each MCO's *LA PQ039 Case Management* report.
Step 2:	**Provide the sample to the MCOs.**
	HSAG provided the sample and oversample to each MCO 10 business days prior to the webinar review. The sample was provided via HSAG's SAFE site.
Step 3:	**Finalize the sample.**
	The MCOs provided HSAG with any requests for exclusions or substitutions to the sample within five business days of receipt of the sample file from HSAG. HSAG provided the final sample to each MCO no later than three business days prior to the webinar.

Activity 3: Webinar Review

HSAG collaborated with the MCOs to schedule and conduct webinar reviews with key MCO staff members to:

- Ensure understanding of terminology and documents used by the MCO to record case management activities.
- Review sampled cases to determine compliance with contractual requirements.

The webinar review consisted of several key activities:

- Entrance Conference: HSAG dedicated the first 15 minutes of each webinar to introduce the activity and the HSAG review team, and to provide key logistics of the review. HSAG reviewed documentation naming conventions with the MCO to ensure understanding of the information that will be displayed by the MCO and reviewed during the activity.
- Case Review: HSAG conducted a review of each sample file. The MCO's case management representative(s) navigated the MCO's case management system and responded to HSAG reviewers' questions. The review team determined evidence of compliance with each of the scored elements on the CMPE review tool. Concurrent interrater reliability was conducted by the HSAG team lead to respond to questions from the review team in real time so that feedback could be provided to the MCO, and any discrepancies addressed, prior to the end of the review.
- Leadership Meeting (optional): HSAG scheduled a meeting with the MCO and LDH to discuss the progress of the review and provide preliminary findings. The meeting also allowed HSAG to confirm information that may be needed to complete the review of cases, and for the MCO to ensure understanding of LDH's expectations.
- Exit Conference: HSAG scheduled a 30-minute exit conference with the MCO and LDH. During the exit conference, HSAG provided a high-level summary of the cases reviewed, preliminary findings, and recommendations to address opportunities for improvement.

Table 9-3—Activity 3: Webinar Review

For this step,	HSAG will…
Step 1:	**Provide the MCOs with webinar dates.**
	HSAG provided the MCOs with their scheduled webinar dates. HSAG considered MCO requests for alternative dates or accommodations.
Step 2:	**Identify the number and types of reviewers needed.**
	HSAG assigned review team members who were content area experts with in-depth knowledge of case management requirements who also had extensive experience and proven competency conducting case reviews. To ensure interrater reliability, HSAG reviewers were trained on the review methodology to ensure that the determinations for each element of the review were made in the same manner.

For this step,	HSAG will…
Step 3:	**Conduct the webinar review.**
	During the webinar, HSAG set the tone, expectations, and objectives for the review. MCO staff members who participated in the webinar reviews navigated their documentation systems, answered questions, and assisted the HSAG review team in locating specific documentation. As a final step, HSAG met with MCO staff members and LDH to provide a high-level summary and next steps for receipt of findings.

Scoring Methodology

HSAG used the CMPE review tool to record the results of the case reviews. HSAG used a two-point scoring methodology. Each requirement was scored as *Met* or *Not Met* according to the criteria identified below. HSAG used a designation of *NA* if the requirement was not applicable to a record; *NA* findings were not included in the two-point scoring methodology.

Met indicated full compliance defined as the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.
- Cases reviewed had documentation that met "due diligence" criteria.

Not Met indicated noncompliance defined as either of the following:

- Cases reviewed did not meet the scoring criteria assigned to each requirement.
- Not all documentation was present.

Not Applicable (NA) indicated a requirement that was not scored for compliance based on the criteria listed for the specific element in the Review Tool and Evaluation Criteria document.

HSAG calculated the overall percentage-of-compliance score for each of the requirements. HSAG calculated the score for each requirement by adding the score from each case, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable cases. Data analysis also included aggregate performance by domain.

Reporting of Abuse, Neglect, or Exploitation (ANE)

If, during the review process, a reviewer identified potential ANE of an enrollee, HSAG reported the concern to the MCO immediately upon identification and to LDH within 24 hours of identification. If the reviewer identified a potential health, safety, or welfare concern that did not rise to the level of an ANE, HSAG reported the concern to the MCO and LDH at the identification of the concern and no later than the end of the webinar review.

Activity 4: Compile and Analyze Findings

Following the webinar review, HSAG compiled and analyzed findings for each MCO. Findings included performance by domain and each scored element. Additional data gathering information may be compiled to inform analysis and results (e.g., program information such as the total number of enrollees in case management during the lookback period).

Domain and Element Performance

Findings were compiled into domains, which represent a set of elements related to a specific case management activity (e.g., assessment, care planning). Domain performance was calculated by aggregating the scores for each element in the domain and dividing by the total number of applicable cases. Domain performance scores provided a high-level result to inform analysis of opportunities for improvement.

Analysis of scored element performance allowed for targeted review of individual elements that may impact overall domain performance. Individual element performance scores were used to inform analysis of specific opportunities for improvement, especially when an element performed at a lower rate than other elements in the domain.

Analysis of findings included identification of opportunities for improvement.

Activity 5: Report Results

HSAG developed a draft and final report of results and findings for each MCO. The report described the scores assigned for each requirement, assessment of the MCO's compliance by domain, and recommendations for improvement. Following LDH's approval of the draft report, HSAG issued the final report to LDH and each MCO.

How Conclusions Were Drawn

Upon completion of the activity, HSAG provided results for each MCO in three performance domains: Assessment, Care Planning, and Enrollee Interaction and Coordination of Services. Each domain included scored elements, displayed in Table 9-4, which demonstrated each MCO's compliance with contractual requirements.

Table 9-4—Assignment of CMPE Measures to the Quality, Timeliness, and Access Domains

CMPE Measure	Quality	Timeliness	Access
The enrollee's initial health needs assessment was completed within 90 calendar days of enrollment.		✓	
The enrollee's initial comprehensive assessment was completed within 90 calendar days of identification of SHCN.		✓	

CMPE Measure	Quality	Timeliness	Access
A reassessment was completed in person quarterly with the enrollee.		✓	
A POC was developed within 30 calendar days of identification of risk stratification.		✓	
A POC was developed within 90 calendar days of identification of risk stratification. (2023 review only)		✓	
The MCO implemented a POC that was developed with the enrollee. (2024 review only)	✓		
The POC includes goals, choices, preferences, strengths, and cultural considerations identified in the assessment. (2024 review only)	✓		
The POC includes interventions to reduce all risks/barriers identified in the assessment. (2024 review only)	✓		
The POC incorporates the BH treatment plan, as applicable. (2024 review only)	✓		
The POC identifies the formal and informal supports responsible for assisting the enrollee. (2024 review only)	✓		
The MCO developed and implemented a person-centered care plan reflective of the most recent assessment and included all enrollee goals, needs, and risks as well as the formal and informal supports responsible for assisting the enrollee with the POC.	✓		
The POC was updated per the enrollee's tier schedule.		✓	
The POC was updated when the enrollee's circumstances or needs changed significantly, or at the request of the enrollee, their parent or legal guardian, or a member of the MCT.	✓		
The MCO developed a MCT, including the case manager, enrollee and/or authorized representative, and members based on the enrollee's specific care needs and goals.	✓		✓
The MCT was convened at regular intervals required for the enrollee's tier level.		✓	
The case manager made valid timely contact, or due diligence is documented in the enrollee's record.		✓	
For enrollees demonstrating needs requiring coordination of services, the case manager coordinated needed care/services, actively linking the enrollee to providers; medical services; and residential, social, community, and other support services.	✓		✓

10. Quality Rating System

Results

The 2024 (CY 2023 [review period]) QRS results for ACLA are displayed in Table 10-1.

Table 10-1—2024 (CY 2023) QRS Results for ACLA

Composites and Subcomposites	ACLA
Overall Rating*	**3.5**
Consumer Satisfaction	**3.5**
Getting Care	2.5
Satisfaction with Plan Physicians	3.5
Satisfaction with Plan Services	3.5
Prevention and Equity	**3.0**
Children and Adolescent Well-Care	2.5
Women's Reproductive Health	2.0
Cancer Screening	3.0
Equity	5.0
Other Preventive Services	4.0
Treatment	**3.0**
Respiratory	3.0
Diabetes	3.5
Heart Disease	3.0
Behavioral Health—Care Coordination	1.0
Behavioral Health—Medication Adherence	2.5
Behavioral Health—Access, Monitoring, and Safety	3.5
Risk-Adjusted Utilization	3.0
Reduce Low Value Care	2.0

**This rating includes all measures in the 2024 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*

ACLA received an Overall Rating of 3.5 points, with 3.5 points for the Consumer Satisfaction composite, 3.0 points for the Prevention and Equity composite, and 3.0 points for the Treatment composite.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- For the Prevention and Equity composite, ACLA received 5.0 points for the Equity subcomposite, demonstrating strength for ACLA related to collecting race and ethnicity information from its members. ACLA also received 4.0 points for the Other Preventive Services subcomposite, demonstrating strength for ACLA related to providing chlamydia screenings in women and tobacco cessation counseling. **[Quality and Access]**

For ACLA, the following opportunities for improvement were identified:

- For the Treatment composite, ACLA received 2.5 points for the Behavioral Health—Medication Adherence subcomposite, demonstrating opportunities for ACLA to ensure members with behavioral health issues stay on prescribed medications. ACLA received 2.0 points for the Reduce Low Value Care subcomposite, demonstrating opportunities for ACLA to ensure members with low back pain do not receive unnecessary imaging tests. ACLA also received 1.0 point for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for ACLA to ensure timely follow-up after hospitalizations and ED visits for mental illness. **[Quality, Timeliness, and Access]**

For ACLA, the following recommendation was identified:

- ACLA should reference the recommendations made in Section 3—Validation of Performance Measures and Section 6—Consumer Surveys: CAHPS-A and CAHPS-C as the 2024 Health Plan Report Card reflects HEDIS and CAHPS results.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the five Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas.[10-1] The 2024 Health Plan Report Card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection

HSAG received MY 2023 CAHPS member-level data files and HEDIS IDSS data files from LDH and the six MCOs. The *HEDIS MY 2023 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2023 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Description of Data Obtained

HSAG received the final, auditor-locked HEDIS IDSS data files from each of the MCOs, as well as the CAHPS member-level data files and summary reports. HSAG also downloaded the 2023 (MY 2022) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[10-2]

How Data Were Aggregated and Analyzed

Using the HEDIS and CAHPS measure results for each MCO, HSAG calculated MCO ratings in alignment with NCQA's 2024 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[10-3]

- Overall
- Consumer Satisfaction
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan Services

[10-1] Due to HUM being a new MCO in 2023, there were no data available for this year's QRS activity. It will be included in a future Health Plan Report Card.

[10-2] 2023 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by August 5, 2024, and 2024 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were not available until September 27, 2024.

[10-3] National Committee for Quality Assurance. 2024 Health Plan Ratings Methodology. Available at: https://www.ncqa.org/wp-content/uploads/2024-HPR-Methodology_Updated-December-2023.pdf. Accessed on: Dec 17, 2024.

- Prevention and Equity
  - Children and Adolescent Well-Care
  - Women's Reproductive Health
  - Cancer Screening
  - Equity
  - Other Preventive Services
- Treatment
  - Respiratory
  - Diabetes
  - Heart Disease
  - Behavioral Health—Care Coordination
  - Behavioral Health—Medication Adherence
  - Behavioral Health—Access, Monitoring, and Safety
  - Risk-Adjusted Utilization
  - Reduce Low Value Care

For each measure included in the 2024 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2023 (MY 2022) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 10-2. For the *Plan All-Cause Readmissions* measure, HSAG followed NCQA's methodology for scoring risk-adjusted utilization measures.

Table 10-2—Measure Rate Scoring Descriptions

Score	MCO Measure Rate Performance Compared to National Benchmarks
5	The MCO's measure rate was at or above the national Medicaid ALOB 90th percentile.
4	The MCO's measure rate was at or between the national Medicaid ALOB 66.67th and 89.99th percentiles.
3	The MCO's measure rate was at or between the national Medicaid ALOB 33.33rd and 66.66th percentiles.
2	The MCO's measure rate was at or between the national Medicaid ALOB 10th and 33.32nd percentiles.
1	The MCO's measure rate was below the national Medicaid ALOB 10th percentile.

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 2024 Health Plan Ratings. For each composite and subcomposite, HSAG calculated scores using the following equation:

$$Composite\ or\ Subcomposite\ Rating = \frac{\sum(Measure\ Rating * Measure\ Weight)}{\sum(Measure\ Weights)}$$

To calculate the Overall Rating, HSAG calculated a weighted average using the weighted measure-level scores previously calculated. HSAG also added 0.5 bonus points to scores for MCOs that were Accredited or had Provisional status, and 0.15 bonus points for MCOs that had Interim status. These bonus points were added to the Overall Rating before rounding to the nearest half-point.

For the Overall Rating and each composite/subcomposite rating, HSAG aligned with NCQA's rounding rules and awarded scores as outlined in Table 10-3.

Table 10-3—Scoring Rounding Rules

Rounded Score	5	4.5	4.0	3.5	3.0	2.5	2.0	1.5	1.0	0.5	0.0
Score Range	≥4.750	4.250–4.749	3.750–4.249	3.250–3.749	2.750–3.249	2.250–2.749	1.750–2.249	1.250–1.749	0.750–1.249	0.250–0.749	0.000–0.249

How Conclusions Were Drawn

For the 2024 Health Plan Report Card, HSAG displayed star ratings based on the final scores for each rating. Stars were partially shaded if the MCO received a half rating (e.g., a score of 3.5 was displayed as 3.5 stars).

11. MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2024 to comprehensively assess ACLA's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides ACLA's strengths, opportunities for improvement, and recommendations in Table 11-1 through Table 11-3.

Table 11-1—Strengths Related to Quality, Timeliness, and Access

Overall MCO Strengths	
Quality	• The 2024 Health Plan Report Card showed that ACLA received 5.0 stars and 4.0 stars for the Equity and Other Preventive Services subcomposites, respectively, demonstrating strength for ACLA in these areas.
Quality, Timeliness, and Access	• ACLA demonstrated strength by developing and carrying out methodologically sound designs and interventions for all five PIPs. • For the NAV audit, ACLA's statewide results met or exceeded LDH-established requirements for statewide provider-to-member ratios by provider type. • For the NAV audit, ACLA's results for behavioral health providers met all LDH-established performance goals for three reported appointment access standards.

Table 11-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall MCO Opportunities for Improvement	
Quality and Access	• The results of the PDV activity indicate opportunities for ACLA to improve access to care for its members.
Quality	• For the CAHPS survey, ACLA's 2024 adult achievement score was statistically significantly lower than in 2023 for *Rating of All Health Care*. • The 2024 Health Plan Report Card showed that ACLA received 2.0 stars for the Women's Reproductive Health and Reduce Low Value Care subcomposites, and 1.0 star for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for improvement for ACLA in these areas.

Table 11-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
To facilitate significant outcomes improvement for all PIPs, HSAG recommends that ACLA review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. ACLA should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed through new or revised interventions to drive outcomes improvement.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities Goal 8: Minimize wasteful spending
HSAG recommends that ACLA evaluate performance measures with rates below the NCQA national 50th percentile.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 5: Improve chronic disease management and control Goal 6: Partner with communities to improve population health and address health disparities Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
HSAG recommends that ACLA conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 5: Improve chronic disease management and control Goal 6: Partner with communities to improve population health and address health disparities

Overall MCO Recommendations	
HSAG recommends that LDH provide ACLA with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which ACLA will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance).	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
HSAG recommends that ACLA conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
HSAG recommends that ACLA consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care

12. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2022–2023 recommendations. Table 12-1 through Table 12-9 contain a summary of the follow-up actions that ACLA completed in response to the EQRO's SFY 2023 recommendations. Furthermore, HSAG assessed ACLA's approach to addressing the recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

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

High indicates *all* of the following:

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

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

Medium indicates one or more of the following:

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

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

Low indicates one or more the following:

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

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

Table 12-1—Follow-Up on Prior Year's Recommendations for PIPs

Recommendations
None identified.

Table 12-2—Follow-Up on Prior Year's Recommendations for Performance Measures

1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
HSAG recommends that ACLA focus its efforts on increasing timely follow-up care for members following discharge. ACLA should also consider conducting a root cause analysis for the Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Mental Illness, and Follow-Up After Emergency Department Visit for Substance Use measures and implement appropriate interventions to improve performance, such as providing patient and provider education and enhancing communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
Response
Describe initiatives implemented based on recommendations: ACLA focused efforts on increasing timely follow-up care or members following hospitalization for mental illness or emergency department visit or mental illness and substance use. The following interventions were initiated as part of this goal: • Transition of Care case managers who are Licensed Mental Health Professionals (LMHPs) are assigned to outreach and complete assessment with members who have a qualifying event to close gaps internally. • Provider visits including education on HEDIS measures, ACLA resources, and ACLA's provider portal containing member discharge information. • Weekly provider notification of member admission to attributed behavioral health provider. • Community Health Navigators (CHNs) outreach members prior to discharge from behavioral health hospitals to assist with appointment scheduling and educating members about follow-up appointments. • All members with a qualifying event are offered case management services; members may decline to enroll. Members who opt out of case management services can still participate in care coordination activities.

1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
• Partnership with telehealth providers to outreach members with qualifying emergency department visits for mental health and substance use. Providers offer care coordination services and appointments that meet follow-up requirements while ensuring members have access to ongoing care in the community. • Assess Social Determinant of Health (SDoH) needs at all contacts with members and refer to appropriate resources depending on need. • Child members who are eligible for Coordinated System of Care (CSoC) services are appropriately referred to the servicing provider. • Texting campaign to send eligible members a text reminder to schedule and attend a follow-up appointment • Members are eligible for a reward for attending a follow-up appointment through ACLA's Care Card program.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • ACLA expects to achieve a 2% increase for the following measures: Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Follow-Up After Emergency Department Visit for Substance Use (FUA). • Weekly provider notification of member admission to attributed behavioral health provider increased from 54.79% in Q4 of 2023 to 92.17% in Q3 of 2024. • Between June and October 2024, Transition of Care case managers who hold licensure as an LMHP completed a total of 262 assessments for FUH, 40 for FUM, and 10 for FUA. Not all assessments may count toward the HEDIS populations for each measure.
Identify any barriers to implementing initiatives: • ACLA has experienced barriers with incoming reports that reflect member admission and discharge from emergency departments, thus delaying outreach to members with qualifying events. This includes facilities who do not report admissions or encounters into Louisiana Health Information Network (LHIN) which inhibits inclusion and timely notification of the encounter on ADT alerts. Other barriers include a high rate of unable to contact (UTC) members due to missing or inaccurate contact information. Appointments are being scheduled by inpatient facilities prior to the member's discharge though members often do not attend appointments.
Identify strategy for continued improvement or overcoming identified barriers: • ACLA is revising various reports to timely identify members with qualifying events for outreach needs to use in conjunction with ADT reports. ACLA is also allocating additional resources to the Transition of Care case management outreach and assessment program to allow for ease of tracking attempts, completions, and timeliness of outreach. Additional resources will include reports with member level detail by completed assessment and eventual inclusion in HEDIS rates.
HSAG Assessment

Recommendations
ACLA should convene a focus group to conduct root cause analyses to determine barriers to child and adolescent members receiving:

Recommendations
• Appropriate use of first-line psychosocial interventions. • Follow-up visits and monitoring of children prescribed ADHD medication. • Appropriate treatment of upper respiratory infections for child members. • Unnecessary screenings for cervical cancer among adolescent females. The focus group should include parent/guardian and provider participation as well as subject matter experts. The focus group should recommend evidenced-based interventions that address barriers. ACLA should consider holistic and novel interventions that aim to improve monitoring rates rather than reiterating previous interventions focused on specific topics or short-term campaigns.
Response
Describe initiatives implemented based on recommendations: ACLA conducted seven Let's CHAT discussion groups. The two consistent barriers identified during the sessions included lack of knowledge related to guidelines/recommendations and lack of transportation to appointments. During the discussion groups, members and guardians were educated on the importance of well-care visits, follow-up appointments, and recommendations of applicable measures. Plan benefits were shared with parents/guardians. Psychosocial interventions implemented: • ACLA developed provider education tools to educate providers on the importance of first-line psychosocial interventions. • Implemented a new incentive program, PerformPlus True Care for Behavioral Health Providers. This program will incentivize participating practitioners who deliver high-quality and cost-effective care, timely care to our members. • Parents/guardians are provided information on psychosocial interventions and directed to provider directory for assistance locating treatment providers • Members educated on available transportation benefit. ADHD interventions implemented: • ACLA developed provider education tools to educate providers on the importance of timely follow-up care for members newly prescribed an ADHD medication. • Lists to providers include information on members who need a follow-up visit. • Outreach and education to members prescribed an ADHD medication on the importance of a follow-up visit. • Provider visits with access to provider report card showing information on the measure • An "ADHD Care Center" section was added to the ACLA website to provide education and guidance to providers on appropriate use and monitoring of children prescribed ADHD medication. • Social media posts prompting parent/guardian to schedule follow-up visits. • Members educated on transportation benefit and telehealth options for gap closure.

Recommendations
Appropriate treatment of upper respiratory infections for child members interventions implemented: • ACLA developed a Low Value Care initiative focused on the appropriate treatment for upper respiratory infections for child members. • *Antibiotic Myths versus Facts* flyer created and mailed to members of high prescribing providers in targeted region. • Education along with flyer shared at community events and at ACLA community wellness centers • Member newsletter article regarding appropriate antibiotic utilization • Education to the high prescribing providers Unnecessary screenings for cervical cancer among adolescent females interventions implemented: • The NCS measure was retired in 2024 by NCQA, therefore data is no longer available for the measure. However, high volume providers for the age group and Cervical Cancer Screening measure were identified for outreach and education. Measure rates and education around cervical cancer screening guidelines are shared with provider groups. Members are outreached and educated on recommendations for cervical cancer screenings. • Measure recommendations shared through Provider Alerts / Newsletters. • Members outreached and educated on recommendations for screening through social media, texting/email campaigns, telephonic campaigns, mailers, community events.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics • Although the measure showed a decline in 2023 rates, year to date 2024 rates are trending .97 percentage points higher than last year. ADHD • Initiation phase increased from 40.76% to 43.83% from 2022 to 2023. The plan met a 2% improvement goal. The rate as of September 2024 has increased to 49.37%, an increase of 5.54%. • Continuation and maintenance phase increased from 51.66% to 52.49% from 2022 to 2023. The 2% improvement goal was not met. The rate as of September 2024 has increased to 54.91%, an increase of 2.42%. Appropriate Treatment of Upper Respiratory Infections • In the 3 month – 17-year-old group, ACLA noted a 1.57 percentage point increase in MY2023 rates when compared to MY2022 rates. Year-to-date rates for My 2024 are trending .52 percentage points higher than the previous year's rate.
Identify any barriers to implementing initiatives:

Recommendations
• A change in Pharmacy Benefits Manager (PBM) resulted in an extended suspension of daily pharmacy reports used for ADHD member outreach. • Some regions of the state have fewer providers able to provide first-line psychosocial interventions to child members.
Identify strategy for continued improvement or overcoming identified barriers: Continue to work with the PBM to facilitate daily pharmacy reports to be used for member outreach for ADHD medication. • Ongoing efforts with PBM for updated reports • Continue to recruit qualified behavioral health providers to provide first-line psychosocial interventions in areas with fewer providers. • Continue to outreach and educate providers/members regarding recommendations and guidelines.
HSAG Assessment

Recommendations
ACLA should consider conducting a root cause analysis for the performance measures that ranked below the NCQA national 50th percentile benchmark and SWA and implementing appropriate interventions to improve performance.
Response

Describe initiatives implemented based on recommendations:
 	
ACLA selected three measures for improvement Controlling Blood Pressure (CBP), Controlling Blood pressure for Patients with Diabetes (BPD) and Cervical Cancer Screenings (CCS). For each measure, a 2% improvement goal was set for improvement. The goals are tracked and monitored monthly.
 	
The interventions implemented for Controlling Blood Pressure and Controlling Blood pressure for Patients with Diabetes include:
• **New initiatives:**
  ○ CPT CAT II Code Targeted Outreach
  ○ Ochsner Health Digital Medicine Program
  ○ Blood Pressure Pocket Guide
  ○ Blood Pressure Poster
  ▪ BP poster with best practices and member education with QR code linked to BP Pocket Guide. Will be placed in clinics and pharmacies.
  ○ CBP medication adherence file development
  ○ CBP 4th Quarter Push Provider Letter
  ○ CBP 4th Quarter Push Member Letter
  ○ Nonstandard Reviews (NSSD)
  ○ Remote Patient Monitoring (RPM) Outreach - Members with Diabetes and/or Hypertension with no outpatient visit in 2024 will be outreached by RPM

Recommendations

- **Continued initiatives:**
  - 4th Quarter gap in care provider push
  - Live telephonic member outreach
  - Remote Patient Monitoring
  - Case Management Program
  - Make Every Calorie Count
  - ACLA Nutrition Program Pilot
  - Women's Wellness Day
  - Social Media
  - Texting campaign
  - Member newsletter article
  - Faith Based education presentation
  - Care Card Member Incentive
  - CPT CAT II Code Add-on: Provider Incentive
  - Provider Alerts regarding recommendations and guidelines
  - Provider Newsletter
  - Quarterly interdepartmental workgroups
  - Provider incentives
  - Multidisciplinary Provider Education

The interventions implemented for Cervical Cancer Screening include:

- New initiatives:
  - Exclusion initiative – EMR record retrieval for members who should be excluded from the denominator
  - Email campaign
  - Postcard mailer to identified disparity
  - CCS Poster with QR Code: Salons, Provider Offices, Colleges and Technical Colleges, Libraries, Gyms
  - Faith Based CCS education presentation
- Continued Initiatives:
  - 4th Quarter gap in care provider push
  - Live telephonic member outreach
  - Disparity Health Fair (Chitimacha Health Fair)
  - Student Wellness Survey during College Days
  - Education during Baby Showers
  - Sticker Campaign: feminine hygiene products and diapers
  - Women's Wellness Day
  - Social Media
  - Texting campaign
  - Member newsletter article
  - Care Card Member Incentive
  - Provider Incentives
  - Provider Alerts regarding recommendations and guidelines
  - Provider Newsletter article

Recommendations

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 	
• **CBP**
  ○ Year-to-date rates show a 10.71 percentage point improvement when compared to the previous year's rates.
• **BPD**
  ○ Year-to-date rates show a 11.57 percentage point improvement when compared to the previous year's rates.
• **CCS**
  ○ Year-to-date rates show a 5.25 percentage point improvement when compared to the previous year's rates.

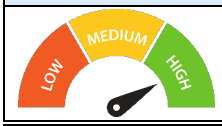
Identify any barriers to implementing initiatives: **CBP/HBD** • Members are often unable to contact • Health literacy • Lack of resources • Unable to take off of work • Childcare not available • Limited transportation • Not taking medications as directed • Negative experience with provider • Language barriers • Long wait times for appointment or lack of availability • Providers' lack of time/staffing constraints/inadequate training/not utilizing telehealth **CCS** • Members are often unable to contact • Low participation in community events/community outreach • Provider unaware of screening recommendations due to changes based on new research • Provider unaware of screening recommendations due to complexity of guidelines • Members with competing priorities, placing preventative care needs as low priority • Lack of emphasis on preventive care • Unclear on HPV testing vs Pap smear • Limited access to technology in order to receive electronic newsletter article, social media posts • Limited primary care providers offering screenings
Identify strategy for continued improvement or overcoming identified barriers: **CBP / HBD**

Recommendations
• Member outreach through mailers, texting, social media, and community events • Help tool on member website • ACLA transportation service • ACLA Nutrition Program Pilot • Make Every Calorie Count • CM Program • Ochsner Health Digital Medicine Program • CBP Medication Adherence File – Track and outreach members who are noncompliant is medication refills • ACLA Mobile Unit • Cooking/Fitness Class in NOLA & Shreveport at Wellness Centers & also potentially provides food boxes • Education/outreach to members & providers on resources for language services during QPS visits and outreach • Quality to complete at least 120 provider visits in 2024, 30 per QPS (149 completed in 2024) • 2024 Q4 Push Provider Letter • Non-Standard Review HEDIS 2024 • CPT CAT II Code Targeted Outreach **CCS** • Persistent presence in communities • Provider trainings and incentives • Member incentives • Research and use of new technology • Case Management • Assist in making screenings simple, utilizing self-testing options recently approved by FDA • Continue to bring messaging to familiar spaces to make health reminders more accessible: messaging that will meet members where they live, work, play, and spend time
HSAG Assessment

Recommendations
Require the MCOs to conduct a root cause analysis for measures associated with members with schizophrenia and implement appropriate interventions to improve performance.
Response
Describe initiatives implemented based on recommendations: • ACLA will utilize existing Serious and Persistent Mental Illness report to continue to provide targeted outreach to offer CM services and education regarding the importance of antipsychotic medication adherence for all members with a diagnosis of Schizophrenia. • ACLA will add two (2) columns to existing Serious and Persistent Mental Illness report for "antipsychotic" medication(s) and, "date of last refill" of antipsychotic medication. BH Care Managers

Recommendations
will provide targeted outreach to address members who are not refilling medications to determine reason medication is not being refilled, provide care coordination to include medication refill reminders and member education. • ACLA will continue to outreach to offer care management services and education to members with diagnosis of Schizophrenia who are referred to Case Management as outlined in Referral/Trigger Criteria policy number 156.202. • Using pharmacy data, ACLA identifies members who may benefit from administration of a long-acting injectable antipsychotic (LAI). If the member is admitted to an inpatient behavioral health facility, ACLA recommends the member begin an LAI during the hospitalization with referral to appropriate aftercare services able to continue and administer ongoing LAIs.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) o Adherence Total: Year-to-date rates show a 5.71 percentage point improvement when compared to the previous year's rates. o Statin Therapy Total: Year-to-date rates show a 2.63 percentage point improvement when compared to the previous year's rates. • Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) o Year-to-date rates show a 2.21 percentage point improvement when compared to the previous year's rates. • Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) o Year-to-date rates show a 5.34 percentage point improvement when compared to the previous year's rates.
Identify any barriers to implementing initiatives: • Difficulty reaching members • Timeline to update existing report and educate Care Managers. • Pharmacists do not receive reimbursement for administering long-acting injectable antipsychotic medications. • Behavioral health hospitals only receive per diem rates and do not receive reimbursement for administering long-acting injectable antipsychotic medications.
Identify strategy for continued improvement or overcoming identified barriers: • Continue targeted outreach, education, care coordination and monitoring. • ACLA continues to research reimbursement policies and opportunities for pharmacists and behavioral health hospitals to administer LAIs. • ACLA will continue outreaching behavioral health hospitals, particularly those with a high-volume of ACLA members admitted, to provide education on LAIs and to assist with identifying aftercare providers able to administer LAIs.
HSAG Assessment

Recommendations
Require the MCOs to conduct a root cause analysis to determine why members are not receiving appropriate treatment of respiratory conditions and implement appropriate interventions to improve performance.

Recommendations
Response
Describe initiatives implemented based on recommendations: • AmeriHealth Caritas Louisiana initiated the "Low Value Care initiative" focusing on the Appropriate Treatment for Upper Respiratory Infection (URI) measure. Jefferson Parish was selected for this initiative as this area demonstrated a high incidence of antibiotic use for URIs when compared to other parishes in Louisiana. Interventions to support this initiative are as follows: "Antibiotic Myths versus Facts" flyer created and mailed to members of high prescribing providers in Jefferson Parish; flyer shared at community events; member newsletter article regarding appropriate antibiotic utilization; and targeted provider education to the high prescribing providers in Jefferson Parish. • ACLA Case Managers will continue to provide education to members regarding appropriate treatment for upper respiratory infection and avoidance of antibiotic treatment for acute bronchitis and bronchiolitis as outlined in applicable Krames-on-Demand education health sheets: ○ **40468 - Acute Bronchitis** ○ **86207 – Bronchiolitis** ○ **90866 – When to use Antibiotics** ○ **90867 – When to use Antibiotics for Your Child** • ACLA case managers continue to educate members regarding the use of primary care providers/urgent care clinics versus emergency department for upper respiratory infections. • Quality trainings with providers cover appropriate treatment for upper respiratory infections and avoidance of antibiotic treatment for acute bronchitis and bronchiolitis.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Comparison of data from the identified population pre and post interventions, showed a 1.74% decrease in antibiotic therapy with a URI diagnosis, 2.34% compared to 0.60%. The Appropriate Treatment for Upper Respiratory Infection (URI) measure demonstrated an increase from MY 2022 to MY 2023, 78.87% to 80.40%.
Identify any barriers to implementing initiatives: Providers do not always adhere to recommendations and guidelines.
Identify strategy for continued improvement or overcoming identified barriers: High utilization providers and members will continue to receive education regarding recommendations and guidelines.
HSAG Assessment

Recommendations
Require the MCOs to focus efforts on decreasing unnecessary imaging and screenings. The MCOs should conduct a root cause analysis and implement appropriate interventions to decrease unnecessary imaging for low back pain and unnecessary screenings for cervical cancer among adolescent females.

Recommendations
Response
Describe initiatives implemented based on recommendations: • The Plan conducted a root cause analysis to decrease unnecessary screenings for cervical cancer and unnecessary imaging for low back pain. High-volume providers were identified for outreach and education. 154 provider education visits completed in 2023; 149 completed as of 10/23/2024. Measure rates and recommendations are shared with provider groups.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Unnecessary Screenings for CCS among adolescent females:** • The NCS measure was retired in 2024 by NCQA, therefore data is no longer available for the measure. However, the plan did see improved CCS provider performance for the current 3 quarters of 2024 when compared to the same quarters in 2023: Quarter 1 demonstrated a 2.25% increase, Quarter 2 demonstrated a 4.36% increase and Quarter 3 demonstrated an 8.22% increase. Current YTD rates for CCS are 5.05 percentage points higher when compared to last year's rates. **Unnecessary Imaging for Low Back Pain** • Current YTD rates for LBP demonstrate a 1.04 percentage point increase when compared to last year's rates
Identify any barriers to implementing initiatives: • NCS data is no longer available due to retired measure. • Providers often face busy schedules and limited time to prioritize staying current with evolving guidelines.
Identify strategy for continued improvement or overcoming identified barriers: • Quality provider education will continue for both high-volume and medium-volume providers throughout the year.
HSAG Assessment

Recommendations
Require the MCOs to focus efforts on increasing timely follow-up care, following discharge, for members who access the hospital and ED for mental illness or substance abuse. The MCOs should conduct a root cause analysis and implement appropriate interventions to improve performance.

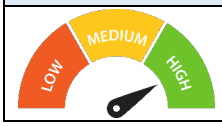
Recommendations
Response
Describe initiatives implemented based on recommendations: ACLA focused efforts on increasing timely follow-up care for members following hospitalization for mental illness or emergency department visit for mental illness and substance use. The following interventions were initiated as part of this goal: • Utilization Management (UM) staff prompting hospitals to schedule follow-up behavioral health appointments prior to member's discharge from the facility. • UM staff monitor percentage of appointments scheduled by entering known appointment dates in the member's Jiva record. • Assess Social Determinant of Health (SDoH) needs at all contacts with members and refer to appropriate resources depending on need. • Outreach activities assigned to third-party providers/vendors for scheduling and completing follow-up appointments, where appropriate. • Combined internal rounds between UM, CM, BH Medical Director to discuss cases and follow-ups. • Transition of Care dedicated staff focus solely on all follow-up activities for every discharge. • Behavioral Health field staff are in the Behavioral Health Hospitals upon alert of a member's admission.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • ACLA expects to achieve a 2% increase for the following measures: Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Follow-Up After Emergency Department Visit for Substance Use (FUA).
Identify any barriers to implementing initiatives: • Member contact information is often incorrect leading to difficulty contacting members to schedule follow-up appointments within necessary timeframes. A second identified barrier is member adherence to appointments.
Identify strategy for continued improvement or overcoming identified barriers: • Improve internal documentation for tracking and reporting to improve timeliness of contact and finding best contact information. As second strategy is incorporating telehealth bridge appointments that are conducted by the admitting provider.
HSAG Assessment


Table 12-3—Follow-Up on Prior Year's Recommendations for Compliance With Medicaid Managed Care Regulations

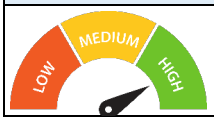
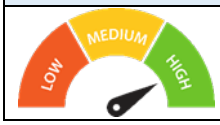
2. Prior Year Recommendations from the EQR Technical Report for Compliance Review:
Require the MCOs to review and update, as appropriate, policies, procedures, manuals, and handbooks to consistently include all member for cause and without cause reasons for disenrollment.
Response
Describe initiatives implemented based on recommendations: Information regarding disenrollment with and without cause is included in the AmeriHealth Caritas Louisiana Member Handbook under the section Loss of Benefits. This section explains to the member the reasons they can be disenrolled from the plan and instructions for voluntary disenrollment. There is also an internal AmeriHealth Caritas Family of Companies Enterprise Operations Policy regarding the disenrollment and enrollment transition guidelines and procedures.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **NA**
Identify any barriers to implementing initiatives: **NA**
Identify strategy for continued improvement or overcoming identified barriers: **NA**
HSAG Assessment


Table 12-4—Follow-Up on Prior Year's Recommendations for Network Adequacy

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
To improve access to care, ACLA should adopt a programmatic approach to identify barriers to access across all aspects of Medicaid operations. A plan wide taskforce should include provider network staff members, subject matter experts for the access-related HEDIS measures that performed poorly, utilization management staff members, and other members as determined by ACLA. The taskforce should include key community stakeholders to identify barriers/facilitators to members accessing preventive and follow-up care. ACLA should consider multi-tiered approaches such as: • Reviewing provider office procedures for ensuring appointment availability standards. • Conducting "secret shopper" provider office surveys. • Evaluating member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
• Conduct drill-down analyses of access-related measures to determine disparities by race, ethnicity, age group, geographic location, etc.
Response
Describe initiatives implemented based on recommendations: ACLA has implemented an Internal Secret Shopper this is completed on a monthly basis by Account Executives. Account Executives pose questions to office staff pertaining to participating practitioners. Questions include but not limited to: • Specialty • Accepting new members • Validating demographic • Validate Phone number and fax • Validate Provider Type/Specialty Type Demographics Access and Availability Survey is completed on an annual basis. ACLA assesses its membership's access to appointments for primary, specialty and behavioral healthcare services. ACLA monitors standards mandated by the Louisiana Department Health (LDH) and the National Committee for Quality Assurance (NCQA) are met. When gaps are identified, ACLA conducts a comprehensive analysis, identifying barriers, opportunities, and appropriate intervention as applicable. Account Executives are educating providers on contract requirements regarding appointment availability standards. Availability of Services Report is completed which analyzes language related disparities. On an annual basis, AmeriHealth Caritas Louisiana assesses its membership access to participating practitioners. ACLA collects and analyzes geographic distribution and provider to member ratios through use of *Quest Analytics*® software, a managed care industry's standard instrument for measuring healthcare network access. The software provides maps, graphs, and tabular reports for analyzing member access to network providers. ACLA reviews and assesses availability for practitioners providing primary, specialty and behavioral healthcare. ACLA, also analyzes member access to assure limited-English Speaking Membership for *threshold languages* (5% or 1,000 or more Members speaking a given language) have access to participating PCPs, pediatric specialists, and high volume/high impact specialist). If opportunities are identified for improvement related to practitioner availability, interventions are implemented to ensure adequate member access to practitioners such as: • Target specific urban and rural parishes for provider recruitment • Promote access to Language Interpretation Services • Educate provider to validate demographics and languages through PDIF ACLA has been working with a telehealth provider providing transition of care for members after an Emergency Room visit. ACLA conducted a drill-down analyses of access-related measures to determine disparities. The following findings were noted: Adults' Access to Preventive/Ambulatory Health Services (AAP) statistically significant disparities: • Regions 1,7 & 8 geographical locations • Ages 20 – 44 age group

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
• Black or African American race Initiation and Engagement of Substance Use Disorder Treatment (IET) statistically significant disparities: • Region 8 geographical location • Ages 18-64 age group for Initiation and Engagement • Black or African American race for Initiation and Engagement Prenatal and Postpartum Care (PPC) statistically significant disparities: • Region 7 geographical location for prenatal and postpartum care • Black or African American for postpartum care Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) **Due to the low denominators, it is difficult to determine true disparities.* • Male population for all age groups • Hispanic ethnicity for all age groups
Identify any noted performance improvement as a result of initiatives implemented (if applicable): When compared to prior year performance: • AAP for the Black or African American population is 3.82 percentage points higher • AAP 20 - 44 age group is 5.08 percentage points higher • IET Initiation 18 – 64 age group is 1.29 percentage points higher • IET Engagement 18 – 64 age group is 1.06 percentage points higher • Postpartum care for the Black or African American population is trending 0.4 percentage points higher.
Identify any barriers to implementing initiatives: • Members/providers unaware of transportation benefits • Members/providers unaware of telehealth options • Lack of childcare to allow members to attend appointments • Unable to identify most current contact information for members
Identify strategy for continued improvement or overcoming identified barriers: • Continue efforts to increase needed providers/specialists in network • Continue to educate members/providers on recommendations, plan benefits • Assist members with appointment scheduling • Expand in-home services • Increase telehealth utilization • Expand face to face visits for members that are unable to be contacted via telephone
HSAG Assessment


Recommendations
To increase accuracy of online provider directories: • Provide each MCO with the case-level PDV data files and a defined timeline by which each plan will address provider data deficiencies. • Require the MCOs to conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
Response
Describe initiatives implemented based on recommendations: A Network Adequacy Project was implemented where the MCO's were given 6 months to review the provider network, outreach providers and make necessary updates and changes. The goal was to remove duplication, and capture providers who may not be employed, retired or deceased and remove them from our network. A snapshot of the network was taken 3/2024 and used to work on the project. This project was completed 9/30/2024.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Network Adequacy results Behavioral Health • Network total - 12,250 • Removed –5,591 • Corrections-1.280 • Ending – 6.791 Physical Health • Network – 36,118 • Removed- 7,737 • Corrections- 1,247 • Ending-28,381
Identify any barriers to implementing initiatives: Lack of communication from provider with demographic updates as well as addition and terminations of practitioners.
Identify strategy for continued improvement or overcoming identified barriers: Account Executives will educate providers at all site visits on network participation, the importance of notifications to MCO on office locations and changes to accepting new patients. Ongoing education to provider on the use of our Provider Data Information Form (PDIF)
HSAG Assessment


Recommendations
To improve compliance with GeoAccess standards: • Require the MCOs to contract with additional providers, if available. • Encourage strategies for expanding the provider network such as enhanced reimbursement or expanding licensing to add additional ASAM LOCs. • Require the MCOs to conduct an in-depth review of provider types for which GeoAccess standards were not met to determine cause for failure and evaluate the extent to which the MCO has requested exemptions from LDH for provider types for which providers may not be available or willing to contract. • Require the MCOs to evaluate whether offering additional telehealth services could increase compliance with GeoAccess standards.
Response
Describe initiatives implemented based on recommendations: We are concentrating recruiting efforts on specific areas of need to contract with additional providers. ACLA offers financial incentives for providers who positively impact the enrollee experience. We will also identify additional opportunities for other VBP programs. ACLA has been working with a telehealth provider providing transition of care for members after an Inpatient Stay or Emergency Room visit. AmeriHealth Caritas is closely examining each parish which shows a need for improved access. We are reviewing our network in comparison to providers that we may not have in our network. ACLA outreached to established providers who offer substance use residential services to determine if they are interested in expanding services to include needed levels of care, specifically in those parishes where there are currently no providers for these services.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): ACLA has shown increases in several different ASAM levels of care in 2024. • ASAM 1-11% • ASAM 2.1-4% • ASAM 2WM-10% • ASAM 3.1-8% • ASAM 3.5-2%
Identify any barriers to implementing initiatives: • Limited provider/member population • Insufficient number of ASAM providers • Insufficient number of PCPs and specialists, including OBGYN, Hematology/Oncology, Endocrinology • Shortage of specialists and reluctance to accept Medicaid.

Recommendations
Identify strategy for continued improvement or overcoming identified barriers: AmeriHealth Caritas is closely examining each parish which shows a need for improved access. We are reviewing our network in comparison to providers that we may not have in our network. Specific outreach to contract is being directed to those providers not in network. ACLA will continue outreach to providers in areas of need to encourage providers to expand or add needed services. ACLA has providers in network who offer telehealth services and are willing and able to offer these services to members in the identified parishes.
HSAG Assessment


Table 12-5—Follow-Up on Prior Year's Recommendations for CAHPS Survey

Recommendations
None identified.

Table 12-6—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey

4. Prior Year Recommendations from the EQR Technical Report for the Behavioral Health Member Satisfaction Survey:
Require the MCOs to implement strategies to increase response rates to the behavioral health member satisfaction survey.
Response
Describe initiatives implemented based on recommendations: • Train member-facing teams to prompt members to complete member surveys during interactions with members. • Increased plan marketing around member surveys, including print materials and social media. • Require member satisfaction survey training/information sessions for all associates. • Call hold reminders for member satisfaction surveys initiated during active survey times. • Provider alerts sent to inform them of upcoming survey dates and the importance of encouraging member participation. • Post-Appointment Pulse Survey to engage members in feedback regarding provider visits.
Identify any noted performance improvement because of initiatives implemented (if applicable): When comparing response rates from prior year, ACLA increased the Adult response rate by 6.62 percentage points and the Child response rate by 6.94 percentage points. ACLA response rates performed above the Healthy Louisiana State Average for both Adult and Child.
Identify any barriers to implementing initiatives: • Unable to contact/locate members

4. Prior Year Recommendations from the EQR Technical Report for the Behavioral Health Member Satisfaction Survey:
• Health Literacy • Survey length and complexity • Member disengagement and skepticism about the survey's purpose
Identify strategy for continued improvement or overcoming identified barriers: ACLA continues to advocate for more user-friendly member satisfaction surveys to increase member participation. Additionally, ACLA will continue to evaluate implemented interventions and modify as needed.
HSAG Assessment


Table 12-7—Follow-Up on Prior Year's Recommendations for Health Disparities Focus Study

Recommendations
None identified.

Table 12-8—Follow-Up on Prior Year's Recommendations for Case Management Performance Evaluation

Recommendations
None identified.

Table 12-9—Follow-Up on Prior Year's Recommendations for Quality Rating System

Recommendations
None identified.

Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from ACLA's Health Equity Plan (HEP) submission from July 2024.

Health Equity Plan

HSAG reviewed ACLA's HEP[A-1] submitted July 2024. HSAG organized the discussions in this report as each MCO presented the topics in its own HEP. Therefore, comparison across the MCOs for the "Development and Implementation of Focus Areas," "Cultural Responsiveness and Implicit Bias Training," and "Stratify MCO Results on Attachment H Measures" sections of the HEP is not possible.

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

Development and Implementation of Focus Areas

1. Health Equity Action Plan by Focus Area

A. Focus Area: Monitoring and Improving Internal Processes

A1 Goal (1): Increased Enrollee Engagement in Plan Programs and Services that support SDOH.

- **Participant Changes** (if applicable): N/A
- **Activities accomplished between January and June 2024:**

Enrollee Advisory Committee

- The Enrollee Advisory Council (EAC) has been leveraged successfully to support the development of standardized questions that improve equity within ACLA's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) communications for Black and Hispanic Enrollees; inform best practices for the EDPST focus group (LET'S CHAT) and provide feedback on the development of the Community Based Organization (CBO) Equity network. To better capture Enrollee needs, the EAC was embedded during all community events. This structure provides a streamlined approach to Enrollee support, an increase in the capturing of Social Determinants of Health (SDOH) needs and addresses a diverse set of barriers during events. Examples of these activities include EACs during Community Baby Showers and *Caritas on the Move*, a series of events that focus on exercise education. To date, the EAC has held 2 adult Enrollee meetings and expanded offerings to create a youth advisory committee (YAC), designated to address the pediatric needs of Enrollees and engage them in their health. One YAC meeting has been accomplished to-date. YAC meetings are executed in school-based settings focused on 7th and 9th grade levels. Over 100 attendees (both AmeriHealth Caritas Louisiana Enrollees and non-enrollees) were in attendance during the first YAC. During these meetings, the YAC discussed topics, including but not limited to, communication preferences and hygiene. ACLA has also been successful in developing relationships with larger Hispanic-serving CBOs to develop solutions tailored to these communities to be addressed in EAC events and outreach.

Following information pertains to EAC Participation:

- March 9, 2024, Enrollee Advisory Council Meeting: 21 Enrollees
- May 7, 2024, Youth Advisory Council Meeting: 12 Enrollees
- June 1, 2024, Enrollee Advisory Council Meeting: 6 Enrollees

Wider Circle:

AmeriHealth Caritas Louisiana expanded work with our affiliate Wider Circle INC (Wider Circle), an organization designed to address health disparities and improve engagement in the health care process, from the Southwest region of Louisiana to the entire state. in late 2023. Wider Circle's approach is built around establishing small groups of people with similar conditions, including SDOH needs, who live in the same neighborhood and have similar ages and backgrounds, serving as a Trusted Delivery Network. Event participation continues to trend positively month-to-month, with a focus of increasing participation in New Orleans and Jefferson parishes.

To date, their continued efforts have identified the top three SDOH needs reported by Enrollee participants: food insecurity, utility, and housing instability. Wider Circle has also made the following referrals to date within these top areas of identified need:

- Food Insecurity: 1551
- Utility: 417
- Housing Instability: 354

Recurring calls with Wider Circle continue to be held to address project needs, barriers to implementation and outreach, and required reporting deliverables. Additionally, there have been increased onsite and virtual training with ACLA staff to coordinate activities.

To date, the number of enrolled participants is 3,017, which exceeds the goal of 2,667. The top 10 parishes of the enrolled membership are represented below. The following image provides a visual of the top ten Parishes with Enrollee participation.

Enrolled Membership by Parish

- **Top 10 Parishes:**

County or Parish	Louisiana Enrolled Member	%GT Louisiana Enrolled Member
East Baton Rouge Parish	618	20.48%
Lafayette Parish	618	20.48%
Calcasieu Parish	263	8.72%
Rapides Parish	235	7.79%
Jefferson Parish	188	6.23%
Orleans Parish	120	3.98%
St. Landry Parish	97	3.22%
St. Martin Parish	84	2.78%
Iberia Parish	81	2.68%
Ascension Parish	75	2.49%
Acadia Parish	55	1.82%
Total	3,017	100.00%

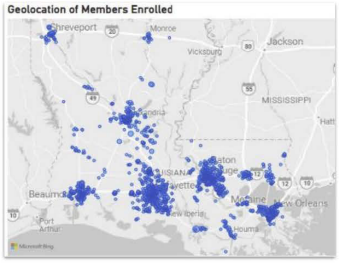


Figure 1 Enrollment by Parish in Wider Circle

Metric	Pacing	Results
Enrolled Participants	At Goal	**3,017** (Goal of 2,667) ○ In-person Event: 20% ○ Virtual Event: 6%
Participant Connections	At Goal	**19,964** (Goal of 9,990) • Telephonic: 76% • In-person event: 20% • Virtual event: 4%
95% Contact rate	At Goal	**96%**
70% Positive Health Actions	At Goal	**71%**
95% SDoH Referral Rate	On Track	**86%**
Net Promoter Score (NPS) > 50	On Track	**78**
Complaint Rate < 3/1000	On Track	**0**

Figure 2 Total Outcomes of Participant Engagement

- **Activities expected to be accomplished by December 2024:**

  Enrollee Advisory Committee

- The Plan will continue to support our Equity strategy by including Care Managers from the Population Health team to discuss our Bright Start, Mom's Meals, and Care Management programs, with the intent to educate Enrollee on these offerings and collect data on barriers to engagement. The conversations are designed to educate Enrollees on Plan offerings that support SDOH associated, maternal care and diabetes management. Ongoing equity enhancement and integration into this activity will be addressed and strategized in recurring Enrollee Engagement equity workgroup discussions, including mechanisms to address language needs. There are two additional EAC and one YAC meetings scheduled through December 2024.
- The Marketing and Communications team, in conjunction with Member and Community Engagement team, partners with the Health Equity Director, Health Equity and Quality Analyst, Community Health Education, Population Health, and Quality to conduct regular assessments of literature and identifying gaps in written materials for ACLA Enrollees. When editing existing or developing new content, consideration for special populations will include:
  - People with health conditions or impairments
  - People with Limited English Proficiency (LEP)
  - People with low health literacy
  - Racial and ethnic minorities
  - Sexual and gender minorities
- Stakeholders will develop a set of standardized questions that address the SDOH and cultural needs of Black and Hispanic Enrollees to be used when collecting information on barriers to Prenatal and Postpartum care, and diabetic care from Enrollees when reviewing communications projects and materials.

Monthly recurring events by Wider Circle through December of 2024:

- Canvassing with the Circle—The facilitator will canvass the targeted area to initiate in-person contact with unique, hard-to-reach Enrollees.
- Nourishing Circle - This event Enrollee will come and receive a hot plate meal and receive resources and information on health and wellness.
- Coffee Chats- During this event, Enrollees will meet for coffee and a light lunch to share life experiences and update the group on the progress of their health journey.
- Let's Talk Chronic Health Conditions – Topics are based on what the Enrollees have in common; topics include Heart Disease, Diabetes, Alzheimer's, etc.

Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2024: No challenges or delays projected.

A1 Goal (2): Engaging of Diverse Families through EPSDT Discussion Groups

- **Participant Changes (if applicable)**: N/A
- **Activities accomplished between January and June 2024**: The Plan's EPSDT team facilitates quarterly group discussions designed to educate and gain insight from Enrollees and caregivers on personal and social challenges faced when accessing health care. The group has been renamed to Let's CHAT (Child Health Activity Talks). Since January 2024, four events have been held. Participation, stratified by self-reported race, ethnicity, and language are as follows:

  - 1st Let's CHAT: Three attendees were African American mothers, all with English language preference
  - 2nd Let's CHAT: One Hispanic mother, one Hispanic adolescent, two white females, two African American fathers and five African American mothers, all with English language preference
  - 3rd Let's CHAT group: Three African American females, all with English language preference
  - 4th Let's CHAT: Proctored in Spanish

- Beginning in January of 2024, the EAC and Wider Circle have assisted in facilitation of Let's CHAT, with positive engagement by plan Enrollees. Barriers discussed by Enrollees include knowledge of activities that should happen during well child visits, knowledge barriers in accessing transportation assistance, and scheduling flexibility with providers. The discussions have been proctored in person, at community events, and one event in Spanish.
- **Activities expected to be accomplished by December 2024:** Let's CHAT will continue meeting with 4 additional events scheduled to be completed by December 2024.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2024:** Initial challenges faced by Let's CHAT centered on preferred communication with participants, which is texting. These challenges and barriers are being addressed to increase participation in forthcoming sessions.

A1 Goal (3): Incorporating the Perspective of the Member

- **Participant Changes (if applicable**): N/A
- **Activities accomplished between January and June 2024**: During the first half of the year, the Marketing and Communication department conducted ongoing reviews of Enrollee-facing collateral at three different member events to ensure that they were comprehensive and cultural relevant.

  At each event, Enrollees reviewed four brochures: Well-Child Visits; Stay Strong, Live Healthy (adults); Stay Strong, Live Healthy (pediatric); and Childhood Immunization checklist.

  Approximately 16 Enrollees participated in the survey over the three events which included:

  1. Community Baby Shower, Monroe on March 9th 2024
  2. ACLA/Wider Circle Event- Conversation with LaTangela & Health Screening Event on April 16, 2024.
  3. 2nd Annual Rosia's Walk & Health Fair- Sickle Cell Anemia Resource Foundation on April 20, 2024.
  4. Member Advisory Council (MAC) meeting- Mansura's Youth Kids on June 1, 2024.

  Summary of the feedback we received:

  - Colorful and eye-catching material.
  - The material was detailed and professional.
  - Lack of diversity of doctors. They would like to see more doctors that look like the community.
  - They liked the female doctor pictured.

- **Activities expected to be accomplished by December 2024:** In the second half of the year through December 2024, we plan to survey Enrollees at three events around updated collateral material that has been edited to include previous member feedback.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2024:** We have reached our milestone of getting feedback on at least four documents. We will surpass that milestone as we head into the second half of the year with more EAC events and meetings still ahead for us to connect with Enrollees. The next item we will have Enrollees look at is the Member Newsletter. Getting feedback on this document will help us improve how we relay messages twice a year to ensure we are making an impact with that material mailed and sent via text to our Enrollees. The biggest challenge that we experience is getting Enrollees to complete the survey. We have asked Enrollees to complete the survey in the moment at the events, rather than sending it with them to complete later. We find that having Enrollees complete while they are present results in more responses. We have seen the increase from the previous year.

B. Focus Area: HEDIS Initiatives

B1 Goal (1): Improved HEDIS Outcomes for Targeted Groups/Geographic Location: Diabetes (CDC) and Maternity (PPC) HEDIS Outcomes for Black, Hispanic and Rural Enrollees

- **Participant Changes:** N/A
- **Activities and achievements accomplished between January and June 2024:**

  Health Equity Tracking Report: The Plan has adopted a Health Equity tracking report that is inclusive of an accompanying toolkit designed by the Health Equity team as a tool to design interventions aimed at populations with disparate outcomes. Ongoing reviews of the memo with the Health Equity team aim to support intervention development through in-depth discussions and planning that address the following memo components:

  - Targeted groups and supporting data.
  - Intervention Timeline.
  - Geographic area targeted for Intervention (where applicable).
  - Providers with care gaps associated with HEDIS measures targeted for improvement.
  - Baseline data and improvement goal.
  - Barriers to care experienced by targeted group.
  - Description of planned actions that support improvement.
  - Effectiveness planned actions.
  - Decision to continue activity or change approach based on outcomes.

  Barriers to Care for Hispanic Enrollees: In the Plan's ongoing efforts to address barriers to care and engagement, discussions have been initiated with AmeriHealth Caritas' Hispanic/Latinx Associate Resource Group to support the formulation of member surveys that address barriers to care specific to Hispanic membership.

- **Activities expected to be accomplished by December 2024:** The plan will continue to use the tracking report and toolkit to measure, report and improve interventions.

- Maternity (PPC)
  - Postpartum appointment reminder letter mailers.
  - Postpartum brochure mailers with information on importance of postpartum visit and postpartum depression.
  - Outreach calls to members while inpatient to assist with scheduling postpartum appointment before discharge.
  - Telephonic follow-up outreach post discharge.
  - Community Health Navigator face to face outreach to members that are unable to contact via telephone that have not attended or scheduled a postpartum appointment.
  - Region 7 Initiatives (Disparate Region):
    - Ochsner Shreveport collaboration with dedicated staff to help schedule members that are nearing the 84-day mark.
    - Additional follow up calls to all unable to contact Black/African American members to assist with scheduling, educating on telehealth if appropriate and transportation as needed.
- Diabetes (CDC)
  - Member reminder letters and outreach calls:
    - Assist with completion of Diabetic screenings (Hemoglobin A1C, Kidney Screening, Retinal Eye Exam); offer assistance with appointment scheduling, transportation
  - Letter to members with most recent Hemoglobin A1C value >9%
    - Educate on importance of retest, diabetic self-management
  - Development of medication adherence pilot program to increase compliance in diabetic members with hypertension
  - Provider reminder letters:
    - Providers billing CPT CAT II codes for Hemoglobin A1C value >9% for attributed members
    - Providers for whom no A1C result billed in measurement year
    - Providers with high noncompliance rates who are not using CPT CAT II codes
  - Quality focused visits, education, care gap closure assistance

- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2024:** No challenges or delays projected.

Focus Area: Community Partnerships and SDOH

C1 Goal (1): Community Based Organization (CBO) Equity Network Development

- **Participant Changes: N/A**
- **Activities and achievements accomplished between January and June 2024:** The Plan is continuing to engage the CBO Equity network in 2024 with the overall objective of increasing engagement of African American and Hispanic Enrollees in Plan programs and services that address SDOH. Participants in the network continue to be engaged monthly to share information on best practices for referrals, discuss patient barriers and explore ways to further leverage existing relationships between Managed Care and Community Based Organizations. The activities since January of 2024 include:
    - The recruitment of three additional CBOs serving rural services areas, and those with predominantly Hispanic and Spanish speaking populations, with special attention to regions 1 and 7.
    - Areas of collaborative focus in 2024, include but are not limited to: post-partum care, Well Child 15 for the African American and Hispanic populations, respectively.
- **Activities expected to be accomplished by December 2024:** A survey has been sent out to participating CBOs, with recruiting efforts focused on Regions 1 and 7, Hispanic, and Spanish speaking CBOs. The toolkit will be finalized with anticipated dissemination by December of 2024. ACLA is developing a toolkit to support CBO's connection to ACLA plan resources. It is currently 25% complete and will address some of the following topics:
    - Plan offerings that address member SDOH, Social Risk Factors and barriers to care.
    - Best practices for referrals and loop closure.
    - Tools for patient advocacy.
    - CBO feedback on community needs.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2024:** No challenges, and/or delays anticipated.

C1 Goal (2): Increased Member Referrals for SDOH needs.

- **Participant Changes: N/A**
- **Activities and achievements accomplished between January and June 2024:** The Plan continues to surpass the improvement goal of 2% increased referrals, year-over-year, doubling the performance of 2023 thus far in 2024. Current referrals to date are below:

2022 Total	2023 Total	2024 January- June
129	382	647

- **Activities expected to be accomplished by December 2024**: Continued development and expansion of activities to drive improvements in SDOH capture.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2024:** No challenges, and/or delays anticipated.

Cultural Responsiveness and Implicit Bias Training

2. Cultural Responsiveness and Implicit Bias Training

A. Staff and provider trainings conducted (e.g., training components, number and type of attendees, length of training and format) between January and June 2024

- Staff
  - Annual Health Equity and Cultural Responsiveness Training 2024-2025 (April 2024): These trainings are required for all new hires and refresher training is required for all new associates. This training is updated annually by the Director of Quality Health Equity and administered and tracked by the Corporate Learning and Development team which provides quarterly reporting for new trainings, which is required upon onboarding.
    - The Plan's 2023 Associate completion rate was 97% annual trainings.
    - New Hire training: One new hire
- Provider Trainings
    - Quarter 1 – February 28, 2024 (8 Registered and 3 Attendees)
    - Quarter 2 – May 22, 2024 (6 Registered, 2 Attendees)
- Training Components
    - Health Equity and Health Inequity
    - Concepts of Equality vs Equity vs Justice
    - Health Disparities
    - Cultural Competency
    - Bias
    - ACLA's Race, Ethnic, and Linguistic membership make-up
    - Importance of building patient trust
    - Social Determinants of Health and their impact on healthcare
    - Concepts of Culturally and Linguistically Appropriate Services
- LGBTQIA+: Sexual Orientation and Gender Identity Data Collection Training: Caritas Louisiana's Population Health team underwent training to prepare for sexual orientation and gender identity (SOGI) data collection from Enrollees. This training is required of all Associates who will complete this process during member encounters. SOGI data collection supports the contractual requirement for assessing the quality of care for Enrollees based on sexual orientation (2.16.2.3.9), and Health Equity Accreditation requirements from the National Committee for Quality Assurance. training was delivered electronically to 39 Care Managers and clinical Community Health Navigators to date. Content included the following:
    - Completing the SOGI assessment in the Plan's health management system.
    - Identifying LGBTQIA+ terminology and basic concepts.
    - Identifying member privacy and confidentiality policies.
    - Recognizing the health disparities that affect LGBTQIA+ people.
    - Understanding why AmeriHealth Caritas is collecting sexual orientation and gender identity data from Enrollees.
    - Using inclusive language and gender pronouns.
    - Using member resources developed to address specific LGBTQIA+ population needs.

- This is a required training for all new hires that are in Care Management.

b. Additional trainings expected to be conducted by December 2024

a. Provider Trainings
   i. August 21, 2024
   ii. November 20, 2024
b. Upcoming Training for Associates
   i. Member Facing Associate Cultural Competency Training (October 23, 2024)

c. **Modifications the MCO has made or intends to make to training content, format, etc. based on participant feedback and lessons learned to date:** We have updated trainings to educate on best practices and new research. Examples of updates include providing clearer guidance of SOGI information and feedback from individuals and member-facing associates; participation in the ALLYSHIP workshop; updates on BIAS training examples and education; and including data on current demographics and languages spoken by the membership.

d. **Is the MCO on track to meet training goals set in the MCO's Health Equity Plan? If not, please describe why not.** The Plan is on track to meet these goals.

Stratify MCO Results on Attachment H Measures

ACLA submitted measure rates with stratification by race, ethnicity, and geography with the HEP submission.