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

External Quality Review Technical Report

Aggregate Report for the Healthy Louisiana Managed Care Organizations

February 2025

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Acknowledgments and Copyrights

1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

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

[1-1] 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 16, 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 16, 2024.

health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 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,	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
	and interpretation of the network 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 2023. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

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

Definitions

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

		
Quality	**Timeliness**	**Access**
as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[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 NEMT and have the MCOs implement interventions to improve provision of non-emergency medical transportation (NEMT) and ensure it is timely and accessible.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH assess areas of noncompliance that resulted in an MCO receiving a notice of

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

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

Actions on External Quality Review Recommendations

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

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

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

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

SFY 2022–2023 EQRO Recommendations	LDH Actions
current and future PIPs. HSAG recommended LDH continue to meet regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could 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.	PIPs. LDH agreed with the EQRO's 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 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

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 and the MCOs in transitioning to HSAG's PIP validation process and methodology. The MCOs actively worked on PIPs throughout SFY 2024, and PIP validation activities were initiated. LDH required the MCOs 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 the MCOs' *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 the MCOs' performance measures confirmed compliance with the standards of 42 CFR §438.330(a)(1). The results of the validation activity determined that each MCO 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 each MCO's independent certified HEDIS compliance auditor, HSAG found that all MCOs 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 excluded from comparison to NCQA national 50th percentile benchmarks.

Of the 278 HEDIS measures/measure indicators with an associated benchmark, LHCC demonstrated the highest performance with 190 indicators performing greater than the NCQA national 50th percentile benchmark, and with ACLA also demonstrating higher performance with 173 indicators performing greater than the NCQA national 50th percentile benchmark. HUM had the most indicators that performed lower than the NCQA national 50th percentile benchmark (132 indicators); however, HUM's results should be reviewed with caution due to its limited period as an MCO in Louisiana. 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 the MCOs prepared to remediate any deficiencies identified during the 2023 CR. HSAG and LDH evaluated the sufficiency of the CAPs. All MCOs demonstrated positive improvements in implementing the CAPs.

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 calendar year (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 the plans showed a low level of agreement between the MCOs' online provider directories and the information obtained during the telephone calls to the providers' offices. Table 1-4 provides a summary of the findings from the study.

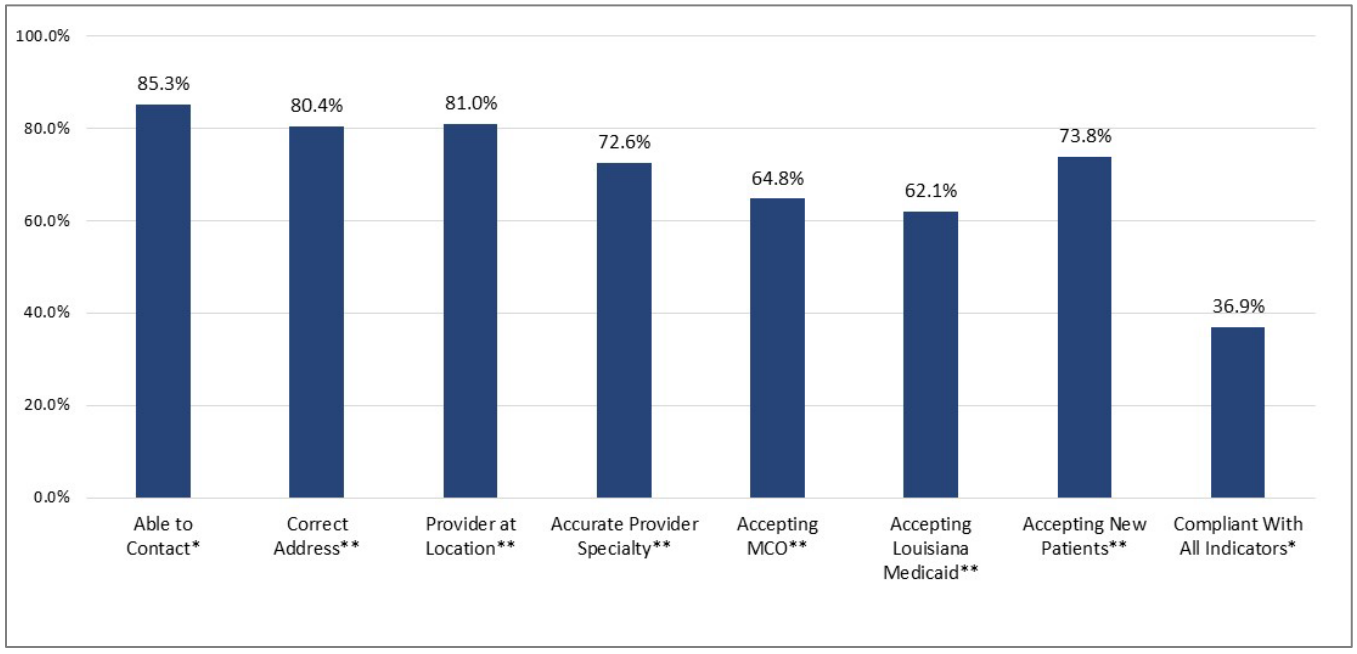
Table 1-4—Summary of PDV Findings

Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 62.1 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 64.8 percent of providers accepted the requested MCO.
Provider's specialty in the provider data was inaccurate.	Overall, 72.6 percent of providers confirmed the specialty listed in the online directory was accurate.
Overall acceptance of new patients was low.	Overall, 73.8 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Address information was inaccurate.	Overall, 80.4 percent of locations confirmed the address listed in the online directory was accurate.
Affiliation with the sampled provider was low.	Overall, 81.0 percent of the locations confirmed affiliation with the sampled provider.

The overall response rate was 85.3 percent, and once contacted, the offices reported varying degrees of match rates for the online provider directory information. The accuracy of the MCO acceptance, Louisiana Medicaid acceptance, and accuracy of the provider's specialty exhibited the lowest match rates. Overall, only 36.9 percent of providers were compliant with all PDV indicators.

Figure 1-1 presents the summary results for all sampled providers and the percent compliant with all PDV indicators.

Figure 1-1—Summary Results for All Sampled Providers



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

Table 1-5 presents the PDV weighted compliance scores by MCO. Please see the NAV methodology for the weighted compliance score calculation criteria.

Table 1-5—PDV Weighted Compliance Scores

MCO	Total	Compliant[1]	Weighted Compliance Score
Total	**3,000**	**1,107**	**44.2%**
ABH	500	122	34.8%
ACLA	500	225	50.8%
HBL	500	175	43.5%
HUM	500	185	42.9%
LHCC	500	211	50.0%
UHC	500	189	43.0%

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

Provider Access Survey

HSAG's provider access survey indicated that, overall, the provider information maintained and provided by the plans showed a low level of agreement between the MCOs' provider data and the information obtained during the telephone calls to the providers' offices. Table 1-6 provides a summary of the findings from the study.

Table 1-6—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 34.2 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 41.1 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, 45.7 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 50.0 percent of providers accepted the requested MCO.
Provider's specialty in the provider data was inaccurate.	Overall, 60.7 percent of providers confirmed the specialty listed in the provider data was accurate.
Address information was inaccurate.	Overall, 84.3 percent of locations confirmed the address listed in the provider data was accurate.

Table 1-7 presents the provider access survey call outcomes.

Table 1-7—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]	Offered Appointment[2]
Total	**71.9%**	**84.3%**	**60.7%**	**50.0%**	**45.7%**	**41.1%**	**34.2%**	**17.9%**
Primary Care	65.3%	86.8%	60.4%	46.4%	39.6%	32.8%	23.0%	24.7%
Pediatrics	78.8%	88.4%	68.3%	61.9%	59.8%	55.6%	50.3%	27.0%
Obstetricians/ Gynecologists (OB/GYNs)	74.2%	78.7%	58.4%	50.6%	49.4%	47.2%	37.1%	16.9%
Endocrinologists	77.7%	79.5%	58.9%	47.9%	43.8%	41.1%	38.4%	6.8%
Dermatologists	70.7%	85.7%	74.3%	55.7%	48.6%	41.4%	40.0%	15.7%
Neurologists	68.3%	81.7%	36.6%	24.4%	24.4%	23.2%	18.3%	2.4%
Orthopedic Surgeons	76.3%	80.0%	61.1%	54.4%	46.7%	42.2%	33.3%	6.7%

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

Table 1-8 and Table 1-9 present the provider access survey weighted compliance scores by specialty and MCO, respectively.

Table 1-8—Provider Access Survey Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**1,151**	**281**	**39.4%**
Primary Care	360	54	29.4%
Pediatrics	240	94	52.5%
OB/GYNs	120	33	42.8%
Endocrinologists	94	27	44.7%
Dermatologists	99	28	36.4%
Neurologists	120	15	37.2%
Orthopedic Surgeons	118	30	40.1%

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

Table 1-9—Provider Access Survey Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**1,151**	**281**	**39.4%**
ABH	188	32	40.4%
ACLA	191	64	43.8%
HBL	194	47	37.6%
HUM	186	73	45.7%
LHCC	200	22	31.2%
UHC	192	43	38.0%

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

Table 1-10 and Table 1-11 display the provider access survey after-hours weighted compliance scores by specialty and MCO, respectively.

Table 1-10—Provider Access Survey After-Hours Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**281**	**86**	**33.8%**
Primary Care	90	26	30.7%
Pediatrics	60	24	42.2%
OB/GYNs	30	11	41.1%
Endocrinologists	20	6	35.0%
Dermatologists	22	4	21.2%
Neurologists	30	9	34.4%
Orthopedic Surgeons	29	6	26.4%

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

Table 1-11—Provider Access Survey After-Hours Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**281**	**86**	**33.8%**
ABH	45	6	15.6%
ACLA	46	14	34.8%
HBL	48	15	34.7%
HUM	45	25	58.5%
LHCC	50	9	21.3%
UHC	47	17	39.0%

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

NAV Audit

HSAG assessed the MCOs' provider-to-member ratios and determined that all MCOs met or exceeded LDH-established thresholds across all provider types.

HSAG assessed the MCOs' submitted distance results and found commonality among the MCOs that met the 100 percent threshold for distance requirements by provider type and urbanicity. Table 1-12 identifies the provider types/urbanicity for which all MCOs met the required LDH threshold for distance.

Table 1-12—Provider Types by Urbanicity, Compliant With Distance Standards Across All MCOs

Provider Type	Urbanicity
Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine and Physician Extenders)	Rural
Pharmacy	Rural

HSAG assessed the appointment timeliness standards and determined that for the three behavioral health standards reported to LDH through the 359 template, all MCOs met the required compliance rate for non-urgent routine behavioral health care. ABH, ACLA, and LHCC met all three timeliness standards. Table 1-13 displays the behavioral health provider access and timeliness standard by visit type, for which performance goals were met by each MCO.

Table 1-13—MCOs That Met Behavioral Health Provider Access and Timeliness Goals, by Standard

Type of Visit	Access/Timeliness Standard	Plans That Met Performance Goal
Emergency Care	24 hours, 7 days/week within 1 hour of request	ABH, ACLA, HBL, LHCC, UHC
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	ABH, ACLA, LHCC
Non-Urgent Routine Behavioral Health Care	14 calendar days	ABH, ACLA, HBL, HUM, LHCC, UHC

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared the Healthy Louisiana SWA'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, the Healthy Louisiana SWA's 2024 adult achievement scores were significantly higher than the 2024 NCQA adult Medicaid national averages for three measures: *Rating of All Health Care*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*. Furthermore, the Healthy Louisiana SWA's 2024 general child achievement scores were significantly higher than the 2024 NCQA general child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly*.

Behavioral Health Member Satisfaction Survey

HSAG compared the Healthy Louisiana SWA's 2024 achievement scores to the corresponding 2023 scores to determine whether there were statistically significant differences. Overall, the Healthy Louisiana SWA's 2024 adult and child scores were not statistically significantly higher or lower than the 2023 scores; therefore, no strengths or opportunities for improvement were identified.

Health Disparities Focus Study

For the 2023 Annual Health Disparities Focus Study, HSAG used MCO-provided CY 2022 stratified HEDIS and non-HEDIS indicator rates to identify disparities based on race, ethnicity, and geography, where applicable. HSAG also used the MCO-provided CAHPS data files to identify disparities based on race and ethnicity. A disparity was identified if the relative difference in an indicator rate between the group of interest (e.g., Black or African American group for the race demographic stratification) and the reference group (e.g., the White group for the race demographic stratification) was greater than 10 percent.

Table 1-14—Overall Statewide Disparities by Demographic Stratification

Demographic Stratification	Better Than the Reference Group	No Disparity Identified	Worse Than the Reference Group
Race (n=41)			
White	—	—	—
American Indian or Alaska Native	6 (37.5%)	7 (43.8%)	3 (18.8%)
Asian	4 (17.4%)	15 (65.2%)	4 (17.4%)
Black or African American	5 (12.2%)	29 (70.7%)	7 (17.1%)
Native Hawaiian or Other Pacific Islander	1 (100.0%)	0 (0.0%)	0 (0.0%)
Other	8 (25.0%)	22 (68.8%)	2 (6.3%)
Unknown	6 (15.8%)	21 (55.3%)	11 (28.9%)
Ethnicity (n=41)			
Non-Hispanic/Latino	—	—	—
Hispanic/Latino	17 (43.6%)	18 (46.2%)	4 (10.3%)
Unknown	6 (14.6%)	21 (51.2%)	14 (34.1%)
Geography (n=15)			
Urban	—	—	—
Rural	0 (0.0%)	10 (66.7%)	5 (33.3%)
Unknown	0 (0.0%)	3 (23.1%)	10 (76.9%)

— indicates the reference group for the select demographic stratification.

The following statewide disparities were found based on race, ethnicity, and geography:

- For the American Indian or Alaska Native group:
  - Rates were suppressed at the statewide level for 25 of 41 indicators, including all 20 indicators based on CAHPS data.
  - Three of the six indicators where the rate for the American Indian or Alaska Native group was better than the rate for the White group were in the Women's Health domain.
  - Two of the three indicators where the rate for the American Indian or Alaska Native group was worse than the rate for the White group were in the Children's Health domain.
- For the Asian group:
  - Rates were suppressed at the statewide level for 18 of 41 indicators, including 17 of the 20 indicators based on CAHPS data.
  - Two of the four indicators where the rate for the Asian group was better than the rate for the White group were in the Children's Health domain.
  - Two of the four indicators where the rate for the Asian group was worse than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization. The other two indicators were in the Behavioral Health domain.
- For the Black or African American group:
  - Three of the five indicators where the rate for the Black or African American group was better than the rate for the White group were in the Women's Health domain.
  - The rates for the Black or African American group were worse than the rates for the White group for most indicators in the Behavioral Health domain.
- For the Native Hawaiian or Other Pacific Islander group:
  - Rates were suppressed at the statewide level for 40 of 41 indicators.
  - The one reportable rate for the Native Hawaiian or Other Pacific Islander group was better than the rate for the White group (*Child and Adolescent Well-Care Visits* [WCV]).
- For the Other group:
  - Four of the eight indicators where the rate for the Other group was better than the rate for the White group were in the Children's Health domain.
  - The two indicators where the rate for the Other group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain.
- For the Unknown race group:
  - Two of the six indicators where the rate for the Unknown race group was better than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization.
  - Six of the 11 indicators where the rate for the Unknown race group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain. Additionally, the rates for the Unknown race group were below the rates for the White race group for all three indicators in the Behavioral Health domain.

- For the Hispanic/Latino group:
  - The rates for the Hispanic/Latino group were better than the rates for the Non-Hispanic/Latino group for 17 of 39 indicators with reportable rates, including all six indicators in the Children's Health domain and four of seven indicators in the Women's Health domain.
  - Two of the four indicators where the rate for the Hispanic/Latino group was worse than the Non-Hispanic/Latino group were in the Chronic Conditions domain, specifically related to hemoglobin A1c (HbA1c) control for diabetes.
- For the Unknown ethnicity group:
  - Four of the six indicators where the rate for the Unknown ethnicity group was worse than the rate for the Non-Hispanic/Latino group were in the Member Experience With Health Plan and Providers domain.
  - The rates for the Unknown ethnicity group were worse than the rates for the Non-Hispanic/Latino group for most measures in the Women's Health and Behavioral Health domains.
- For the Rural group:
  - No rates for the Rural group were better than the rates for the Urban group.
  - Four of the five indicators where the rate for the Rural group was worse than the rate for the Urban group were in the Women's Health domain, specifically related to postpartum contraception utilization.
- For the Unknown geography group:
  - No rates for the Unknown geography group were better than the rates for the Urban group.
  - The rates for the Unknown geography group were worse than the rates for the Urban geography group for all five indicators in the Children's Health domain and two of the three indicators in the Women's Health domain.

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 for all MCOs, which were used by LDH to inform guidance and develop CAPs to address performance. The following strengths were identified for the MCOs statewide:

- 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 five of the six MCOs were successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans, and multidisciplinary care team (MCT) development.

While the MCOs achieved successes with initial enrollee engagement case activities, all six MCOs demonstrated the following opportunities for improvement:

- Elements related to ongoing scheduled case management activities.
- Although the MCOs reported varying levels of success with enrollee engagement, they were generally unable to demonstrate use of alternative options for engagement. HSAG observed limited documentation of attempts to contact enrollees' formal or informal supports (i.e., physicians, BH professionals, pharmacists, personal assistants/homemakers) to assist with engagement attempts. In addition, while all six MCOs had unable to reach (UTR) processes to assist with enrollee engagement, the MCOs were unable to demonstrate consistent application of those processes.
- For the CY 2024 review, although the MCOs were generally successful in developing a plan of care (POC) with enrollees, there was opportunity for improvement related to person-centered planning.

Specific findings and recommended actions were provided to the MCOs through HSAG's CAP process. All MCOs successfully completed remediation actions to address the CAP findings, and the CAPs were 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, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.5 stars. For the Consumer Satisfaction composite, one MCO (UHC) received 5.0 stars, two MCOs (HBL and LHCC) received 4.0 stars, and two MCOs (ABH an ACLA) received 3.5 stars. For the Prevention and Equity composite, ACLA, HBL, and UHC each received 3.0 stars, while ABH and LHCC received the lowest ratings at 2.5 stars. For the Treatment composite, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.0 stars.

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

Aggregate Results

SFY 2024 (review period) was the second year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs 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 each MCO.

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, the MCOs collaborated on improvement strategies, meeting at least monthly collectively with LDH, throughout the year. The MCOs 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 the MCOs 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, the MCOs will submit the 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 the MCOs' final PIP validation results and confidence ratings delivered by HSAG in April 2024.

Table 2-3—SFY 2024 PIP Validation Results for Each MCO

MCO	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]
ABH	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
	Ensuring Access to the COVID-19 Vaccine	85%	89%	*Low Confidence*	33%	100%	*Moderate Confidence*

MCO	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]
	Among Healthy Louisiana Enrollees						
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*No 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*		
ACLA	*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*
	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*		
HBL	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Ensuring Access to the COVID-19 Vaccine	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

MCO	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]
	Among Healthy Louisiana Enrollees						
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*No 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*		
HUM	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	*Not Assessed*		
	Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	*Not Assessed*		
	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*		
LHCC	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Ensuring Access to the COVID-19 Vaccine	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

MCO	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]
	Among Healthy Louisiana Enrollees						
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	100%	100%	*High 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*		
UHC	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*Low 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 ABH's *Behavioral Health Transitions of Care* PIP.

Table 2-4—Performance Indicator Results for ABH's *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: 469 D: 2,845	16.49%	N: 567 D: 3,162	17.93%			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 968 D: 2,845	34.02%	N: 1,132 D: 3,162	35.80%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 85 D: 451	18.85%	N: 117 D: 585	20.00%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 141 D: 451	31.26%	N: 190 D: 585	32.48%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 115 D: 903	12.74%	N: 291 D: 1,312	22.18%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 166 D: 903	18.38%	N: 431 D: 1,312	32.85%▲			*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 *Behavioral Health Transitions of Care* PIP.

Table 2-5—Performance Indicator Results for ACLA's *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 2-6 displays data for HBL's *Behavioral Health Transitions of Care* PIP.

Table 2-6—Performance Indicator Results for HBL's *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: 1,183 D: 6,113	19.35%	N: 1,205 D: 6,047	19.93%			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 2,285 D: 6,113	37.38%*	N: 2,206 D: 6,047	36.48%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 197 D: 1,070	18.41%	N: 236 D: 1,136	20.77%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 325 D: 1,070	30.37%	N: 405 D: 1,136	35.65%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 149 D: 1,597	9.33%	N: 403 D: 2,129	18.93%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 234 D: 1,597	14.65%	N: 600 D: 2,129	28.18%▲			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
* Baseline percentage for FUH—Total, 30 Days was calculated from the MCO's reported numerator and denominator. The MCO's reported baseline percentage could not be replicated using the reported numerator and denominator values.
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 2-7 displays data for HUM's *Behavioral Health Transitions of Care* PIP. For HUM, CY 2023 was the baseline measurement period for this PIP topic because the MCO began operations for the Louisiana Medicaid Program on January 1, 2023.

Table 2-7—Performance Indicator Results for HUM's *Behavioral Health Transitions of Care* 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
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 183 D: 1,417	12.91%					*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 406 D: 1,417	28.65%					*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 39 D: 274	14.23%					*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 57 D: 274	20.80%					*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 79 D: 613	12.89%					*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 122 D: 613	19.90%					*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 2-8 displays data for LHCC's *Behavioral Health Transitions of Care* PIP.

Table 2-8—Performance Indicator Results for LHCC's *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: 1,673 D: 9,156	18.27%	N: 1,717 D: 8,592	19.98% ▲			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 3,551 D: 9,156	38.78%	N: 3,444 D: 8,592	40.08%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 401 D: 1,804	22.23%	N: 349 D: 1,593	21.91%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 679 D: 1,804	37.64%	N: 598 D: 1,593	37.54%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 462 D: 2,912	15.87%	N: 309 D: 2,336	13.23%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 759 D: 2,912	26.06%	N: 509 D: 2,336	21.79%			*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 2-9 displays data for UHC's *Behavioral Health Transitions of Care* PIP.

Table 2-9—Performance Indicator Results for UHC's *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: 1,595 D: 7,632	20.90%	N: 1,432 D: 7,065	20.27%			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 2,931 D: 7,632	38.40%	N: 2,619 D: 7,065	37.07%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 351 D: 1,469	23.89%	N: 268 D: 1,322	20.27%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 541 D: 1,469	36.83%	N: 429 D: 1,322	32.45%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 495 D: 3,021	16.39%	N: 308 D: 2,198	14.01%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 785 D: 3,021	25.98%	N: 482 D: 2,198	21.93%			*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 2-10 displays data for ABH's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-10—Performance Indicator Results for ABH's *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: 61,361 D: 119,997	51.14%	N: 59,054 D: 115,387	51.18%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 53,937 D: 119,997	44.95%	N: 51,794 D: 115,387	44.89%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 19,056 D: 43,319	43.99%	N: 17,074 D: 39,406	43.33%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 25,516 D: 45,109	56.57%	N: 26,603 D: 46,500	57.21% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 4,292 D: 9,858	43.54%	N: 6,093 D: 13,510	45.10% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 12,497 D: 21,711	57.56%	N: 9,284 D: 15,971	58.13%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 16,691 D: 43,319	38.53%	N: 14,964 D: 39,406	37.97%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 22,353 D: 45,109	49.55%	N: 23,249 D: 46,500	50.00%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 3,580 D: 9,858	36.32%	N: 5,166 D: 13,510	38.24% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 11,313 D: 21,711	52.11%	N: 8,415 D: 15,971	52.69%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 2,381 D: 38,752	6.14%	N: 2,960 D: 10,318	28.69% ▲	*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 complete COVID-19 vaccine series, ages 12–15 years	N: 1,975 D: 38,752	5.10%	N: 2,341 D: 10,318	22.69% ▲	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 2,246 D: 38,752	5.80%	N: 2,688 D: 19,834	13.55% ▲	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 1,679 D: 38,752	4.33%	N: 1,995 D: 19,834	10.06% ▲	*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 2-11 displays data for ACLA's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-11—Performance Indicator Results for ACLA's *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*

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 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*
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 2-12 displays data for HBL's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-12—Performance Indicator Results for HBL's *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: 30,214 D: 219,679	13.75%	N: 96,273 D: 209,541	45.94% ▲	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 15,214 D: 219,679	6.93%	N: 83,615 D: 209,541	39.90% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 5,802 D: 52,643	11.02%	N: 28,120 D: 75,297	37.35% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 9,020 D: 66,408	13.58%	N: 45,044 D: 86,175	52.27% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 1,589 D: 14,926	10.65%	N: 10,140 D: 23,983	42.28% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 13,803 D: 85,702	16.11%	N: 12,969 D: 24,086	53.84% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 2,811 D: 52,643	5.34%	N: 24,482 D: 75,297	32.51% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 4,633 D: 66,408	6.98%	N: 38,763 D: 86,175	44.98% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 699 D: 14,926	4.68%	N: 8,652 D: 23,983	36.08% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 7,071 D: 85,702	8.25%	N: 11,718 D: 24,086	48.65% ▲	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 8,870 D: 29,084	30.50%	N: 5,699 D: 22,057	25.84%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 7,252 D: 29,084	24.93%	N: 4,543 D: 22,057	20.60%	*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 5–11 years	N: 7,598 D: 53,137	14.30%	N: 4,744 D: 39,943	11.88%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 7,598 D: 53,137	14.30%	N: 3,580 D: 39,943	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 2-13 displays data for HUM's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP. For HUM, CY 2023 was the baseline measurement period for this PIP topic because the MCO began operations for the Louisiana Medicaid Program on January 1, 2023.

Table 2-13—Performance Indicator Results for HUM's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 32,865 D: 89,181	36.85%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 32,107 D: 89,181	36.00%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 8,762 D: 27,125	32.30%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 14,191 D: 32,780	43.29%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 3,459 D: 9,737	35.52%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 6,453 D: 19,539	33.03%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 8,600 D: 27,125	31.71%	*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 13,858 D: 32,780	42.28%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 3,321 D: 9,737	34.11%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 6,328 D: 19,539	32.39%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 2,865 D: 13,200	21.70%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 2,751 D: 13,200	20.84%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 2,289 D: 24,390	9.38%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 2,103 D: 24,390	8.62%	*Not Assessed*

N–Numerator D–Denominator
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 2-14 displays data for LHCC's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-14—Performance Indicator Results for LHCC's *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: 150,623 D: 336,359	44.78%	N: 124,270 D: 270,672	45.91% ▲	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 129,645 D: 336,359	38.54%	N: 107,600 D: 270,672	39.75% ▲	*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 dose of COVID-19 vaccine among White enrollees	N: 41,242 D: 119,944	34.38%	N: 33,099 D: 93,939	35.23% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 79,610 D: 155,173	51.30%	N: 65,336 D: 122,176	53.48% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 10,501 D: 25,647	40.94%	N: 11,914 D: 28,898	41.23%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 19,270 D: 35,595	54.14%	N: 13,921 D: 25,659	54.25%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 35,546 D: 119,944	29.64%	N: 28,617 D: 93,939	30.46% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 67,955 D: 155,173	43.79%	N: 56,347 D: 122,176	46.12% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 8,796 D: 25,647	34.30%	N: 10,044 D: 28,898	34.76%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 17,348 D: 35,595	48.74%	N: 12,592 D: 25,659	49.07%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 17,507 D: 59,394	29.48%	N: 12,340 D: 48,927	25.22%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 14,427 D: 59,394	24.29%	N: 10,043 D: 48,927	20.53%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 12,916 D: 99,784	12.94%	N: 9,492 D: 85,725	11.07%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 9,712 D: 99,784	9.73%	N: 7,248 D: 85,725	8.45%	*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 2-15 displays data for UHC's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-15—Performance Indicator Results for UHC's *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: 158,887 D: 335,991	47.29%	N: 119,684 D: 252,981	47.31%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 137,938 D: 335,991	41.05%	N: 104,396 D: 252,981	41.27%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 45,155 D: 122,415	36.89%	N: 33,425 D: 90,389	36.98%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 79,360 D: 145,822	54.42%	N: 59,696 D: 108,441	55.05% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 11,429 D: 26,498	43.13%	N: 11,963 D: 27,638	43.28%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 22,943 D: 41,256	55.61%	N: 14,600 D: 26,512	55.07%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 39,032 D: 122,415	31.88%	N: 29,122 D: 90,389	32.22%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 68,438 D: 145,822	46.93%	N: 51,809 D: 108,441	47.78% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 9,726 D: 26,498	36.70%	N: 10,211 D: 27,638	36.95%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 20,742 D: 41,256	50.28%	N: 13,254 D: 26,513	49.99%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 15,882 D: 50,655	31.35%	N: 11,152 D: 41,553	26.84%	*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 complete COVID-19 vaccine series, ages 12–15 years	N: 13,230 D: 50,655	26.12%	N: 9,192 D: 41,553	22.12%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 12,161 D: 85,529	14.22%	N: 8,401 D: 69,611	12.07%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 9,290 D: 85,529	10.86%	N: 6,455 D: 69,611	9.27%	*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 2-16 displays data for ABH's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-16—Performance Indicator Results for ABH's *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: 152 D: 3,300	4.60%	N: 135 D: 3,478	3.88%			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 291 D: 4,060	7.16%	N: 281 D: 4,450	6.31%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 280 D: 6,680	4.19%	N: 262 D: 7,080	3.70%			*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 723 D: 14,040	5.15%	N: 678 D: 15,008	4.52%			*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 2-17 displays data for ACLA's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-17—Performance Indicator Results for ACLA's *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*
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.
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 2-18 displays data for HBL's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-18—Performance Indicator Results for HBL's *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: 497 D: 12,112	4.10%	N: 232 D: 33,509	0.69%			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,233 D: 19,645	6.28%	N: 225 D: 54,200	0.42%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 1,010 D: 40,446	2.50%	N: 245 D: 122,656	0.20%			*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 2,740 D: 72,203	3.79%	N: 702 D: 210,365	0.33%			*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 2-19 displays data for HUM's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP. For HUM, CY 2023 was the baseline measurement period for this PIP topic because the MCO began operations for the Louisiana Medicaid Program on January 1, 2023.

Table 2-19—Performance Indicator Results for HUM's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* 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
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 137 D: 3,064	4.47%					*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
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 335 D: 4,611	7.27%					*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 403 D: 10,506	3.84%					*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 875 D: 18,181	4.81%					*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 2-20 displays data for LHCC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-20—Performance Indicator Results for LHCC's *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: 1,612 D: 14,780	10.91%	N: 2,014 D: 15,383	13.09% ▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,205 D: 19,605	6.15%	N: 1,448 D: 19,548	7.41% ▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 858 D: 22,133	3.88%	N: 946 D: 22,215	4.26% ▲			*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: 3,675 D: 56,518	6.50%	N: 4,408 D: 57,146	7.71%▲			*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 2-21 displays data for UHC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-21—Performance Indicator Results for UHC's *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: 647 D: 16,029	4.04%	N: 517 D: 12,368	4.18%			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,306 D: 22,170	5.89%	N: 1,174 D: 21,191	5.54%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 1,367 D: 52,878	2.59%	N: 1,338 D: 49,387	2.71%			*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 3,320 D: 91,077	3.65%	N: 3,029 D: 82,946	3.65%			*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.
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 2-22 displays data for ABH's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-22—Performance Indicator Results for ABH's *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: 14,749 D: 30,785	47.91%					*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 2-23 displays data for ACLA's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-23—Performance Indicator Results for ACLA's *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 2-24 displays data for HBL's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-24—Performance Indicator Results for HBL's *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: 32,114 D: 75,714	42.41%					*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 2-25 displays data for HUM's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-25—Performance Indicator Results for HUM's *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: 3,647 D: 18,497	19.72%					*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 2-26 displays data for LHCC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-26—Performance Indicator Results for LHCC's *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: 46,964 D: 89,499	52.47%					*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 2-27 displays data for UHC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-27—Performance Indicator Results for UHC's *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: 28,000 D: 137,209	20.40%					*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 2-28 displays data for ABH's *Screening for HIV Infection* PIP.

Table 2-28—Performance Indicator Results for ABH's *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	N: 2,154	57.04%					*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
year among pregnant persons or persons with encounters for labor and delivery	D: 3,776						
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 3,225 D: 9,390	34.35%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,238 D: 10,890	48.10%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 25,261 D: 79,552	31.75%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 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 2-29 displays data for ACLA's *Screening for HIV Infection* PIP.

Table 2-29—Performance Indicator Results for ACLA's *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*
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*

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 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 Remeasurements 1 and 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 2-30 displays data for HBL's *Screening for HIV Infection* PIP.

Table 2-30—Performance Indicator Results for HBL's *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: 8,289 D: 12,391	66.89%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 5,469 D: 19,431	28.14%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,764 D: 8,893	64.82%					*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 ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 21,728 D: 234,488	9.27%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 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 2-31 displays data for HUM's *Screening for HIV Infection* PIP.

Table 2-31—Performance Indicator Results for HUM's *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: 2,700 D: 4,894	55.17%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 1,077 D: 2,810	38.33%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 2,408 D: 4,073	59.12%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 5,395 D: 76,165	7.08%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 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 2-32 displays data for LHCC's *Screening for HIV Infection* PIP.

Table 2-32—Performance Indicator Results for LHCC's *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: 10,679 D: 14,450	73.90%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 7,803 D: 26,295	29.67%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 20,917 D: 51,895	40.31%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 42,423 D: 163,580	25.93%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 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 2-33 displays data for UHC's *Screening for HIV Infection* PIP.

Table 2-33—Performance Indicator Results for UHC's *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: 9,161 D: 14,124	64.86%					*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: 6,463 D: 18,657	34.64%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 14,067 D: 23,190	60.66%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 89,701 D: 90,472	99.15%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 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 2-34 through Table 2-39 summarize the MCOs' CY 2023 barriers and interventions.

Table 2-34—Barriers and Interventions Reported by ABH for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge • Providers do not receive details of enrollee's diagnosis and discharge plan • Enrollees not aware of the importance of follow-up care	• Enhanced admission, discharge, and transfer (ADT) data exchange for BH related emergency department (ED) visits and hospital stays. • Information technology (IT) system enhancements to connect follow-up providers with *Follow-Up After Hospitalization for Mental Illness* discharge plans. • Enrollee follow-up educational campaign to provide information on the importance of follow-up visits and assist with follow-up appointment scheduling.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Enrollees may not remember to obtain the second dose of a two dose vaccine series	• Distributed eligible enrollee lists and vaccination site lists to PCPs and facilitate referrals as needed.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application • Lack of enrollee parent/guardian understanding of benefits and importance of fluoride varnish treatment	• Enhanced MCO case management enrollee outreach and education with dental provider appointment scheduling. • Utilization of technology to ensure education on receiving fluoride varnish treatment in PCP offices for guardians of eligible enrollees. • Educate PCPs on the practice of applying fluoride varnish in the office setting and appropriate documentation of Current Procedural Terminology (CPT) code 99188. • Worked with providers to ensure that fluoride varnish treatments are occurring in the office.

PIP Topic	Barriers	Interventions
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Enrollees may not remember to schedule annual preventive appointments, which include cervical cancer screening	• Enrollee education regarding Centers for Disease Control and Prevention (CDC) cervical cancer screening guidelines related to recommended ages, types of screening methods, and populations who should receive screening. • Telephonic and text outreach campaigns to eligible enrollees to provide appointment scheduling and transportation assistance for cervical cancer screening. • Partnered with Crescent Care clinic to provide a community event that included enrollee education and the opportunity for enrollees to be screened during the event.
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Text message campaign and printed enrollee educational materials on HIV statistics and HIV screening guidelines. • Community events to provide enrollees with HIV education and screening opportunities.

Table 2-35—Barriers and Interventions Reported by ACLA for Each 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 ADT notification report of inpatient admits from *Follow-Up After Hospitalization for Mental Illness* population. • Utilization of ADT notification report of ED admits or discharges from *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. • Utilization of ADT notification report to determine case management notification of ED admits or

PIP Topic	Barriers	Interventions
		discharges from *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 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.

PIP Topic	Barriers	Interventions
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.

Table 2-36—Barriers and Interventions Reported by HBL for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Members forget to schedule appointments • Providers' lack of resources to schedule timely appointments	• Enhance hospital-to-MCO workflow for notification of hospital and ED ADTs. • Text message campaign to provide assistance with scheduling follow-up appointments.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of transportation and lack of access to nearby vaccine sites • Lack of understanding of vaccine safety and benefits	• Developed and implemented COVID-19 vaccination outreach to enrollees engaged in case management. • Outreach calls to those enrollees who have not completed the vaccination series (not received second dose).
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of member education and access to appointments • Lack of provider education	• Community outreach events for enrollees. • Provider outreach and education using care gap report, American Academy of Pediatrics (AAP) guidelines on fluoride use to prevent dental caries, LDH bulletin on fluoride varnish training reimbursement and course requirements, and Well-Ahead Louisiana resources.

PIP Topic	Barriers	Interventions
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of provider awareness of CDC screening guidelines and recommendations • Lack of enrollee knowledge of the screening procedure	• Education provided for enrollees in case management on what to expect during a cervical cancer screening and to address fear of the procedure. • Educational text campaign for enrollees not in case management to provide information on screening guidelines.
Screening for HIV Infection	• Enrollee fear of screening results • Lack of enrollee awareness on importance of HIV screening and CDC recommendations	• Developed an educational HIV screening outreach campaign for enrollees in case management. • Worked with a vendor to carry out an educational HIV screening text campaign for enrollees not in case management. • Collaborated with analytical staff to create an HIV screening gaps in care report for provider distribution.

Table 2-37—Barriers and Interventions Reported by HUM for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Case management team is only alerted on members that have a certain risk level • Lack of means to track scheduled visits	• Enhance hospital-to-MCO workflow for notification of hospital and ED ADTs.
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	• COVID-19 vaccinations offered at all community events and referrals to pharmacies for vaccinations were offered to enrollees. • Incentivized enrollees for COVID-19 vaccination by promoting the Shots Per 100,000 program.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of enrollee knowledge on fluoride varnish education and access to screening	• Developed HUM branded oral health/fluoride varnish application educational collateral to be distributed at community events. • Partnered with a community health organization that focuses on oral

PIP Topic	Barriers	Interventions
		health to train HUM health workers to apply fluoride varnish. • Uploaded provider education links, including the Smiles for Life training, to the provider portal.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of provider awareness of CDC screening guidelines and recommendations	• *Cervical Cancer Screening* text message campaign to outreach all eligible enrollees 21–64 years of age who were identified on the *Cervical Cancer Screening* care gap report. • Quarterly provider visits by Quality and Provider Relations teams to offer provider education on using Compass, a centralized reporting platform, to view enrollee care gaps as well as the process for gap closure through attestation or upload of medical records.
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Developed HUM branded educational material about the importance of HIV screening for distribution at relevant HUM sponsored events. • Quality/Provider Relations representatives met with provider groups to provide education on HIV screening recommendations for each group of eligible enrollees.

Table 2-38—Barriers and Interventions Reported by LHCC for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Limited behavioral health provider participation in ADT feeds/applications • Lack of engagement from members with substance use disorders (SUD) in follow-up care	• Enhanced hospital-to-MCO workflow for notification of hospital ADTs. • Linkage to aftercare with BH providers prior to discharge from hospital.
Ensuring Access to the COVID-19 Vaccine Among	• Lack of access to the COVID-19 vaccine	• Distributed eligible enrollee lists and vaccination site lists to PCPs and facilitated referrals as needed.

PIP Topic	Barriers	Interventions
Healthy Louisiana Enrollees	• Challenges with reaching a large volume of eligible members via case management outreach alone	• Distributed vaccination site lists to PCPs. • Eligible enrollees due for the second dose of COVID-19 vaccine outreached with reminder communications to facilitate completion of the vaccination series.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application • Lack of enrollee parent/guardian understanding of need to establish a dental provider	• Provider outreach and education using care gap report, AAP guidelines on fluoride use to prevent dental caries, LDH bulletin regarding reimbursement and course requirements/link, and Well-Ahead Louisiana resources. • Provided PCPs with customized list of enrollees for whom fluoride varnish application was indicated.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Lack of provider knowledge of proper coding to capture screening	• Enhanced MCO case management enrollee outreach for enrollees with no cervical cancer screening (care gap) and assisted with appointment scheduling at OB/GYN. • Enhanced MCO case management enrollee outreach or education on cervical cancer screening. • Conducted provider outreach and education on cervical cancer screening guidelines and billing/coding guidelines.
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening • Enrollee's lack of transportation to screening appointments	• Enhanced MCO outreach for pregnant enrollees providing appointments scheduled for HIV screening. • Provider engagement and education regarding updated clinical practice guidelines for HIV screening, provider incentives, current enrollee incentives, billing/coding guidelines, and gaps in care report distribution.

Table 2-39—Barriers and Interventions Reported by UHC for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge • Difficult to engage enrollees in follow-up treatment	• Enhanced hospital-to-MCO workflow for notification of hospital and ED ADTs through analyzing ADT feeds. • Linked enrollees to aftercare with BH providers prior to discharge from hospital or ED. • Contracted with provider, Eleanor Health, to provide proactive outreach and assistance in securing follow-up appointments and other case management needs for enrollees with SUD.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to COVID-19 vaccine • Challenges with reaching a large volume of eligible members via case management outreach alone • Enrollees may not remember to obtain second dose of two-dose vaccine series	• Developed and implemented COVID-19 vaccination outreach to enrollees not engaged in case management. • Live telephonic outreach with second vaccine dose reminder and scheduling assistance.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application	• Provider education on the availability and use of care gap reports to identify enrollees due for fluoride varnish application. • Targeted outreach calls for enrollee groups with fluoride varnish application disparities (enrollees residing in Region 1, Native American/Indian enrollees, Alaskan Native enrollees, Native Hawaiian or Pacific Islander enrollees, and enrollees in foster care).
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of guidelines for cervical cancer screening	• Educational outreach to enrollees in case management to provide education on cervical cancer screening and Medicaid transportation benefits. • Distribution of provider education materials and toolkit on cervical cancer screening.

PIP Topic	Barriers	Interventions
Screening for HIV Infection	• Lack of enrollee and provider knowledge on guidelines for HIV screening and on resources for obtaining screening	• Provided enhanced case management outreach for HIV screening education for all eligible pregnant enrollees in case management. • Provided enhanced case management outreach for HIV screening education to all eligible enrollees 15–65 years of age in case management.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs 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 MCOs carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCOs 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 MCOs statewide, the following opportunities for improvement were identified:

- Although some improvement in performance indicator results has been achieved across the three PIP topics with reported remeasurement results, there continues to be room for improvement in achieving significant improvement in outcomes across all PIP topics for all MCOs. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following recommendations were identified:

- To facilitate significant outcomes improvement for all PIPs, the MCOs 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 MCOs 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 2-40.

Table 2-40—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	✓	✓	✓

3. Validation of Performance Measures

Aggregate Results

Information Systems Standards Review

HSAG reviewed the FARs produced for each MCO by the MCO's independent certified HEDIS compliance auditor to ensure that each MCO calculated its rates based on accurate data and according to NCQA's established standards.

The FARs include information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, medical record review validation (MRRV) results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. HSAG analyzed the MCOs' HEDIS MY 2023 results and evaluated each MCO's current performance levels in reference to NCQA's Quality Compass national Medicaid percentiles.

HSAG evaluated each MCO's IS to verify accurate HEDIS reporting. As part of the evaluation, each FAR, which contained the licensed organization's (LO's) assessment of IS capabilities, was reviewed. The IS evaluation focused on aspects of the MCOs' systems that could affect the HEDIS Medicaid reporting set.

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. The final audit results included final determinations of validity made by the independent certified HEDIS compliance auditor for each performance measure. The IDSS file detailed all rates that were submitted to NCQA and whether the LO deemed them to be reportable.

HSAG used the FAR and the MCO rates provided on the Interactive Data Submission System (IDSS) file as the primary data sources. Based on a review of the FARs issued by each MCO's independent certified HEDIS compliance auditor, HSAG found that the MCOs were determined to be fully compliant with all four of the applicable NCQA IS standards. HEDIS rates produced by the MCOs were reported to NCQA.

The MCOs' compliance with IS standards are highlighted in Table 3-1.

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

IS Standard	MY 2022					MY 2023					
	ABH	ACLA	HBL	LHCC	UHC	ABH	ACLA	HBL	HUM	LHCC	UHC
IS R—Data Management and Reporting (formerly IS 6.0, IS 7.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
IS C—Clinical and Care Delivery Data (formerly IS 5.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
IS M—Medical Record Review Processes (formerly IS 4.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	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 measures 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. Rates highlighted in **red** indicate the measure or SWA performance fell below the NCQA national 50th percentile, and rates highlighted in **green** indicate that the measure or SWA performance was at or above the NCQA national 50th percentile. Table 3-2 through Table 3-5 display a summary of the MCOs' HEDIS measure performance.

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

	MY 2022						MY 2023						
HEDIS Measure	**ABH**	**ACLA**	**HBL**	**LHCC**	**UHC**	**SWA**	**ABH**	**ACLA**	**HBL**	**HUM**	**LHCC**	**UHC**	**SWA**
Follow-Up After Hospitalization for Mental Illness													
Within 7 Days of Discharge	17.29%	18.77%	20.35%	18.74%	20.90%	19.52%	18.61%	19.82%	23.27%	15.12%	20.70%	20.73%	**20.67%**
Within 30 Days of Discharge[I]	35.27%	36.26%	39.26%	39.48%	38.41%	38.33%	37.03%	38.49%	41.13%	32.48%	41.60%	39.16%	**39.62%**
Follow-Up After Emergency Department Visit for Mental Illness													
Within 7 Days of Discharge	20.18%	22.93%	21.35%	22.54%	23.89%	22.45%	20.76%	20.59%	24.63%	15.15%	22.39%	22.84%	**22.26%**
Within 30 Days of Discharge [I]	33.57%	35.30%	36.44%	37.76%	36.83%	36.52%	33.39%	31.59%	41.69%	22.35%	38.24%	37.68%	**36.83%**
Follow-Up After Emergency Department Visit for Substance Use[B]													
Within 7 Days of Discharge	22.24%	17.38%	16.87%	15.88%	16.39%	17.19%	15.38%	12.51%	13.28%	8.95%	13.42%	14.40%	**13.46%**
Within 30 Days of Discharge [I]	33.81%	28.94%	27.70%	26.05%	25.98%	27.70%	24.59%	20.50%	21.45%	14.86%	21.89%	22.92%	**21.75%**
Plan All-Cause Readmissions*													
Observed Readmissions (Numerator/Denominator)	10.37%	10.21%	9.76%	9.52%	11.14%	10.15%	11.18%	10.73%	9.32%	NA	10.06%	10.37%	**10.13%**
Expected Readmissions Rate	9.79%	9.65%	9.56%	9.40%	9.65%	9.57%	10.38%	10.04%	9.40%	NA	9.62%	10.00%	**9.77%**
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.0594	1.0574	1.0214	1.0122	1.1540	1.0603	1.0778	1.0691	0.9911	NA	1.0460	1.0376	**1.0368**
Depression Screening and Follow-Up for Adolescents and Adults													
Depression Screening (Total)	0.00%	2.59%	0.00%	0.00%	0.58%	1.00%	0.78%	2.37%	NR	0.08%	NR	0.85%	**1.06%**
Follow-Up on Positive Screen (Total)	0.00%	54.11%	0.00%	0.00%	72.73%	58.25%	83.33%	51.12%	NR	NA	NR	74.14%	**62.50%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.33%	84.13%	82.84%	82.52%	82.08%	82.78%	85.69%	84.73%	84.08%	92.86%	83.89%	83.96%	**84.36%**
Diabetes Monitoring for People With Diabetes and Schizophrenia	63.26%	69.07%	66.89%	67.44%	68.64%	67.47%	70.70%	71.29%	72.14%	70.69%	73.32%	72.74%	**72.29%**
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.65%	75.81%	73.42%	76.84%	81.71%	76.14%	83.33%	80.00%	79.75%	NA	81.91%	82.43%	**81.53%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics													
Blood Glucose Testing	56.23%	54.74%	57.32%	52.04%	55.99%	54.46%	60.00%	54.61%	57.96%	NA	52.36%	55.96%	**54.92%**
Cholesterol Testing	30.70%	29.05%	33.38%	25.42%	30.63%	28.80%	30.00%	25.00%	31.27%	NA	25.93%	30.19%	**28.09%**
Blood Glucose and Cholesterol Testing	30.70%	28.09%	32.61%	24.73%	29.76%	28.05%	29.38%	24.42%	30.48%	NA	24.86%	29.38%	**27.21%**
Lead Screening in Children	62.04%	66.91%	62.86%	61.64%	65.45%	63.59%	67.64%	69.83%	64.73%	43.59%	68.13%	64.24%	**66.40%**
Childhood Immunization Status													
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	61.56%	70.80%	69.34%	68.13%	67.88%	68.23%	70.32%	71.28%	72.51%	57.69%	70.45%	72.75%	**71.31%**
Polio Vaccine, Inactivated (IPV)	81.51%	88.81%	86.13%	89.05%	85.64%	87.00%	88.32%	87.53%	87.83%	79.17%	87.42%	86.37%	**87.17%**
Measles, Mumps, and Rubella (MMR)	80.29%	85.64%	83.45%	85.16%	84.43%	84.34%	84.43%	86.28%	88.08%	75.64%	86.33%	85.16%	**86.06%**
Haemophilus Influenzae Type B (HiB)	79.32%	85.16%	83.45%	84.67%	85.40%	84.33%	86.86%	85.44%	85.89%	77.24%	85.92%	85.40%	**85.66%**
Hepatitis B	83.45%	89.54%	87.83%	91.00%	87.59%	88.75%	90.02%	90.29%	89.78%	81.41%	90.35%	86.86%	**89.20%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Varicella-Zoster Virus (VZV)	80.29%	85.64%	83.70%	85.40%	83.94%	84.35%	84.67%	85.77%	89.05%	77.24%	86.44%	85.40%	**86.30%**
Pneumococcal Conjugate	64.48%	69.34%	70.32%	66.91%	69.83%	68.57%	67.40%	70.76%	73.97%	58.65%	69.52%	71.53%	**70.65%**
Hepatitis A	77.62%	81.75%	80.78%	80.78%	80.78%	80.70%	80.78%	84.15%	87.10%	77.56%	83.73%	82.73%	**83.82%**
Rotavirus	65.69%	65.45%	66.42%	67.15%	66.91%	66.63%	63.99%	66.61%	63.02%	62.18%	63.61%	63.99%	**63.96%**
Influenza	25.06%	28.22%	27.25%	27.98%	23.60%	26.49%	25.30%	20.30%	23.11%	14.74%	20.46%	21.17%	**21.26%**
Combination 3[I]	57.66%	63.50%	64.72%	61.80%	62.04%	62.44%	63.02%	64.95%	67.88%	51.60%	63.80%	65.94%	**64.96%**
Combination 7	50.36%	54.26%	55.23%	51.82%	54.01%	53.35%	50.85%	55.46%	54.74%	45.51%	52.45%	53.77%	**53.34%**
Combination 10	17.27%	22.87%	21.65%	20.92%	18.00%	20.30%	17.03%	16.04%	19.22%	8.65%	15.61%	15.33%	**16.16%**
Immunizations for Adolescents													
Meningococcal	76.89%	83.21%	82.73%	83.76%	84.67%	83.48%	79.32%	84.67%	83.21%	81.31%	86.60%	87.59%	**85.85%**
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	76.40%	83.70%	83.70%	84.46%	85.89%	84.30%	79.08%	85.40%	83.45%	81.31%	87.10%	88.08%	**86.29%**
Human Papillomavirus (HPV)	30.17%	40.39%	40.15%	37.60%	41.12%	39.08%	37.96%	45.01%	41.61%	34.42%	39.18%	45.26%	**41.77%**
Combination 1	75.91%	82.97%	82.24%	83.59%	84.67%	83.26%	78.59%	84.67%	83.21%	80.71%	86.36%	87.35%	**85.64%**
Combination 2[I]	29.68%	40.39%	39.90%	37.27%	40.39%	38.69%	37.47%	44.77%	41.61%	34.12%	38.87%	45.01%	**41.53%**
Colorectal Cancer Screening[I]	31.85%	35.17%	32.94%	34.06%	34.48%	33.81%	43.21%	44.95%	40.60%	67.18%	44.28%	43.82%	**43.44%**
Flu Vaccinations for Adults Ages 18 to 64	33.33%	40.86%	35.98%	35.14%	37.77%	36.62%	—	—	—	—	—	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents													
Body Mass Index (BMI) Percentile Documentation	77.62%	73.20%	77.13%	60.58%	83.21%	72.22%	80.05%	75.37%	76.89%	77.37%	81.51%	83.21%	**80.09%**
Counseling for Nutrition	66.67%	62.28%	62.53%	57.18%	68.86%	62.46%	65.69%	64.39%	64.23%	63.02%	70.56%	58.39%	**64.97%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Counseling for Physical Activity	62.29%	53.35%	55.96%	51.58%	60.10%	55.47%	63.50%	62.20%	59.61%	60.34%	59.12%	50.85%	**57.89%**
HIV Viral Load Suppression[I]	80.62%	75.50%	80.86%	79.78%	77.60%	79.04%	85.13%	80.81%	83.48%	73.46%	81.99%	82.05%	**82.26%**
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.67%	23.59%	26.97%	27.47%	26.47%	26.61%	27.93%	25.06%	26.32%	23.54%	27.18%	26.41%	**26.35%**
Chlamydia Screening in Women													
Total	59.22%	64.40%	60.72%	63.84%	64.02%	63.13%	64.55%	64.32%	64.50%	66.75%	67.37%	65.49%	**65.84%**
Breast Cancer Screening	54.72%	55.54%	55.07%	55.74%	57.11%	55.83%	—	—	—	—	—	—	—
Controlling High Blood Pressure[I]	59.85%	59.90%	53.77%	55.23%	61.31%	57.62%	63.26%	60.80%	56.93%	69.10%	60.34%	61.80%	**60.47%**
Statin Therapy for Patients With Cardiovascular Disease													
Received Statin Therapy—Total	81.37%	81.14%	80.54%	80.41%	80.50%	80.66%	82.75%	83.76%	83.00%	83.02%	81.94%	82.82%	**82.74%**
Statin Adherence 80%—Total	73.65%	67.81%	63.87%	73.30%	63.81%	67.86%	75.15%	68.02%	57.89%	67.42%	74.18%	61.52%	**66.40%**
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes													
Poor HbA1c Control (>9.0%)[,I]*	33.09%	39.66%	37.47%	45.99%	34.55%	38.96%	33.33%	33.09%	30.66%	27.25%	31.63%	23.60%	**29.55%**
HbA1c Control (<8.0%)	56.20%	53.04%	53.77%	44.77%	57.91%	52.48%	59.61%	59.61%	62.29%	66.91%	61.56%	70.07%	**63.65%**
Eye Exam for Patients With Diabetes	52.31%	50.36%	55.23%	53.04%	55.72%	53.85%	46.96%	51.09%	55.47%	54.74%	59.37%	54.74%	**55.06%**
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)	61.31%	56.20%	64.48%	50.61%	67.15%	59.93%	62.29%	64.48%	63.50%	71.78%	63.02%	70.07%	**65.25%**
Pharmacotherapy for Opioid Use Disorder	34.26%	29.55%	22.62%	34.90%	21.84%	27.67%	38.41%	34.07%	24.55%	61.18%	34.11%	21.85%	**29.53%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Initiation and Engagement of Substance Use Disorder (SUD) Treatment													
Initiation of SUD Treatment	60.02%	64.68%	65.35%	55.86%	58.78%	60.37%	61.26%	65.10%	58.91%	59.40%	49.81%	60.16%	**57.95%**
Engagement of SUD Treatment	25.54%	28.33%	28.52%	21.55%	25.97%	25.62%	26.94%	30.10%	25.02%	26.91%	15.87%	28.17%	**24.37%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67.24%	60.06%	65.71%	60.10%	67.86%	63.46%	68.80%	56.83%	64.93%	67.65%	61.74%	65.02%	**63.06%**
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.81%	55.42%	47.03%	59.14%	48.69%	53.17%	58.31%	57.23%	50.89%	64.55%	60.69%	51.27%	**55.72%**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication													
Initiation Phase	43.29%	40.70%	40.71%	42.92%	44.13%	42.65%	43.17%	49.75%	45.21%	NA	44.21%	46.24%	**45.52%**
Continuation Phase	60.00%	51.99%	53.59%	54.84%	58.40%	55.44%	63.39%	56.83%	53.66%	NA	51.43%	58.55%	**54.23%**
Antidepressant Medication Management													
Effective Acute Phase Treatment	60.92%	54.72%	55.41%	56.85%	53.91%	55.83%	61.92%	56.31%	55.53%	72.53%	59.73%	55.90%	**57.61%**
Effective Continuation Phase Treatment	45.35%	36.31%	37.51%	39.76%	35.51%	38.18%	46.12%	38.89%	37.60%	61.54%	42.60%	36.41%	**39.77%**
Appropriate Treatment for Children With Upper Respiratory Infection	79.17%	78.87%	79.93%	79.95%	79.48%	79.64%	79.68%	80.40%	80.11%	99.68%	80.12%	80.14%	**80.50%**
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	51.77%	53.82%	52.80%	52.58%	49.60%	51.85%	50.75%	54.77%	52.78%	98.14%	51.12%	48.99%	**51.81%**
Use of Imaging Studies for Low Back Pain	69.73%	72.61%	71.66%	71.47%	70.81%	71.31%	67.96%	69.88%	69.31%	70.31%	69.11%	69.60%	**69.31%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Non-Recommended Cervical Screening in Adolescent Females*	0.58%	2.08%	0.58%	2.07%	2.37%	1.81%	0.50%	2.45%	0.67%	1.33%	2.05%	2.51%	**1.85%**
Cervical Cancer Screening[I]	52.07%	55.36%	53.37%	56.69%	61.07%	56.53%	48.66%	56.27%	50.61%	30.17%	58.64%	56.45%	**53.47%**
Asthma Medication Ratio													
5–11 Years	—	—	—	—	—	—	84.14%	80.10%	80.20%	NA	79.44%	68.99%	**76.33%**
12–18 Years	—	—	—	—	—	—	85.71%	72.42%	78.00%	NA	74.41%	59.53%	**69.59%**
19–50 Years	—	—	—	—	—	—	74.73%	71.56%	76.56%	NA	72.27%	56.98%	**68.05%**
51–64 Years	—	—	—	—	—	—	81.82%	69.89%	75.98%	NA	69.43%	55.61%	**67.00%**
Total	—	—	—	—	—	—	79.36%	73.49%	77.55%	NA	74.21%	60.16%	**70.18%**
Topical Fluoride for Children													
1–2 Years	—	—	—	—	—	—	1.42%	6.32%	5.60%	2.27%	6.54%	2.24%	**4.76%**
3–4 Years	—	—	—	—	—	—	0.64%	9.66%	7.93%	0.88%	10.52%	0.93%	**6.32%**
Total	—	—	—	—	—	—	1.00%	7.97%	6.79%	1.50%	8.55%	1.56%	**5.56%**
Oral Evaluation, Dental Services													
0–2 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
3–5 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
6–14 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
15–20 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
Total	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**

* Indicates a lower rate is desirable.
[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.
Caution is recommended when comparing HUM's MY 2023 rates to other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

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

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Adults' Access to Preventive/Ambulatory Health Services													
20–44 Years	62.73%	68.28%	69.98%	72.25%	73.82%	70.84%	67.99%	68.12%	68.95%	53.57%	76.80%	75.53%	**71.25%**
45–64 Years	75.53%	78.39%	79.52%	81.11%	82.51%	80.13%	80.95%	79.39%	78.32%	57.41%	84.67%	84.90%	**80.87%**
65 Years and Older	71.82%	73.00%	75.56%	78.18%	75.65%	75.93%	68.44%	76.08%	69.42%	88.09%	82.46%	74.54%	**79.46%**
Total	67.43%	71.44%	72.84%	74.69%	76.47%	73.65%	72.59%	71.66%	71.81%	55.59%	79.11%	78.57%	**74.25%**
Prenatal and Postpartum Care													
Timeliness of Prenatal Care	76.40%	85.67%	85.07%	81.51%	82.97%	82.86%	81.02%	80.33%	82.97%	80.05%	78.83%	87.59%	**82.12%**
Postpartum Care	80.05%	76.83%	78.47%	75.18%	77.37%	77.00%	77.37%	73.77%	78.59%	76.64%	77.62%	77.37%	**77.27%**

Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.
Caution is recommended when comparing HUM's MY 2023 rates to the LDH target rates or other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

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

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Well-Child Visits in the First 30 Months of Life													
First 15 Months	58.55%	58.63%	58.59%	58.57%	62.07%	59.52%	68.42%	65.05%	62.83%	NA	63.17%	66.33%	**64.44%**
15 Months–30 Months	61.09%	63.54%	62.53%	63.41%	66.66%	63.95%	70.22%	69.78%	70.09%	NA	70.49%	69.64%	**70.10%**
Child and Adolescent Well-Care Visits													
3–11 Years	50.72%	54.64%	51.96%	55.24%	56.29%	54.57%	54.70%	57.12%	55.27%	50.03%	59.98%	58.94%	**57.47%**
12–17 Years	43.09%	52.08%	47.63%	52.49%	52.84%	51.26%	50.85%	53.65%	50.25%	46.88%	56.83%	56.04%	**54.10%**
18–21 Years	22.79%	26.97%	24.80%	27.83%	28.28%	27.04%	27.60%	28.92%	26.05%	22.23%	32.59%	30.21%	**29.30%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total	43.80%	48.50%	45.52%	49.12%	49.99%	48.34%	48.72%	51.04%	48.13%	44.11%	54.23%	52.93%	**51.39%**
Ambulatory Care													
Outpatient Visits/1,000 Member Years	4303.35	4670.87	4849.70	4932.72	5284.83	4930.50	4,490.94	4,494.01	5,103.55	3,422.64	5,253.10	5,420.48	**4,958.45**
*Emergency Department Visits/1,000 Member Years**	745.11	764.19	742.68	736.87	753.17	746.42	774.29	732.55	729.10	559.12	762.05	758.06	**735.72**
Inpatient Utilization—General Hospital/Acute Care													
Maternity—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	18.18	30.40	32.31	27.64	27.27	NQ	**28.03**
Maternity—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	119.74	147.31	143.70	133.39	171.84	NQ	**149.64**
Maternity—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	3.04	2.10	0.88	2.27	1.97	NQ	**1.85**
Maternity—Days/1,000 Member Years—Total	—	—	—	—	—	—	65.55	80.47	85.16	76.06	88.82	NQ	**82.50**
Maternity—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	6.53	10.17	11.12	9.37	9.65	NQ	**9.72**
Maternity—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	43.12	52.99	52.75	50.04	63.18	NQ	**54.81**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Maternity—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	0.64	0.66	0.36	0.71	0.63	NQ	**0.56**
Maternity—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	23.48	28.68	31.10	28.18	32.50	NQ	**30.03**
Maternity—Average Length of Stay—10–19 Years	—	—	—	—	—	—	2.78	2.99	2.91	2.95	2.82	NQ	**2.88**
Maternity—Average Length of Stay—20–44 Years	—	—	—	—	—	—	2.78	2.78	2.72	2.67	2.72	NQ	**2.73**
Maternity—Average Length of Stay—45–64 Years	—	—	—	—	—	—	4.78	3.16	2.45	3.18	3.13	NQ	**3.29**
Maternity—Average Length of Stay—Total	—	—	—	—	—	—	2.79	2.81	2.74	2.70	2.73	NQ	**2.75**
Surgery—Days/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	571.55	315.98	370.01	283.82	616.39	NQ	**463.70**
Surgery—Days/1,000 Member Years—1–9 Years	—	—	—	—	—	—	25.02	23.41	44.47	13.53	39.42	NQ	**33.47**
Surgery—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	34.62	31.24	31.35	18.52	36.85	NQ	**32.49**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Surgery—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	133.18	103.34	101.72	82.79	110.61	NQ	**106.78**
Surgery—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	370.27	359.41	328.32	344.01	379.07	NQ	**356.86**
Surgery—Days/1,000 Member Years—65–74 Years	—	—	—	—	—	—	259.16	266.28	371.28	622.78	288.59	NQ	**393.71**
Surgery—Days/1,000 Member Years—75–84 Years	—	—	—	—	—	—	616.49	695.44	1,170.53	1,050.05	651.36	NQ	**944.71**
Surgery—Days/1,000 Member Years—86 Years and Older	—	—	—	—	—	—	1,922.33	NA	0.00	548.66	508.73	NQ	**584.92**
Surgery—Days/1,000 Member Years—Total	—	—	—	—	—	—	154.00	112.99	127.42	95.80	124.12	NQ	**123.56**
Surgery—Discharges/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	22.30	17.48	18.25	13.58	23.45	NQ	**19.95**
Surgery—Discharges/1,000 Member Years—1–9 Years	—	—	—	—	—	—	3.42	3.39	3.76	2.16	3.91	NQ	**3.54**
Surgery—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	4.64	3.96	4.65	3.01	4.66	NQ	**4.35**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Surgery—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	14.90	13.28	14.13	10.82	15.65	NQ	**14.26**
Surgery—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	42.51	42.99	40.53	41.26	45.86	NQ	**42.97**
Surgery—Discharges/1,000 Member Years—65–74 Years	—	—	—	—	—	—	40.77	34.73	38.67	65.75	27.20	NQ	**42.16**
Surgery—Discharges/1,000 Member Years—75–84 Years	—	—	—	—	—	—	57.35	73.98	58.95	107.42	66.81	NQ	**87.74**
Surgery—Discharges/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	145.63	NA	0.00	50.34	59.85	NQ	**51.79**
Surgery—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	16.89	13.48	15.50	11.42	14.23	NQ	**14.43**
Surgery—Average Length of Stay—Less than 1 Year	—	—	—	—	—	—	25.63	18.08	20.28	20.89	26.29	NQ	**23.24**
Surgery—Average Length of Stay—1–9 Years	—	—	—	—	—	—	7.32	6.91	11.83	6.26	10.08	NQ	**9.44**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Surgery—Average Length of Stay—10–19 Years	—	—	—	—	—	—	7.47	7.89	6.74	6.16	7.90	NQ	**7.46**
Surgery—Average Length of Stay—20–44 Years	—	—	—	—	—	—	8.94	7.78	7.20	7.65	7.07	NQ	**7.49**
Surgery—Average Length of Stay—45–64 Years	—	—	—	—	—	—	8.71	8.36	8.10	8.34	8.27	NQ	**8.31**
Surgery—Average Length of Stay—65–74 Years	—	—	—	—	—	—	6.36	7.67	9.60	9.47	10.61	NQ	**9.34**
Surgery—Average Length of Stay—75–84 Years	—	—	—	—	—	—	10.75	9.40	19.86	9.78	9.75	NQ	**10.77**
Surgery—Average Length of Stay—85 Years and Older	—	—	—	—	—	—	13.20	NA	0.00	10.90	8.50	NQ	**11.29**
Surgery—Average Length of Stay—Total	—	—	—	—	—	—	9.12	8.38	8.22	8.39	8.72	NQ	**8.56**
Medicine—Days/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	464.15	447.26	401.07	405.50	399.89	NQ	**414.29**
Medicine—Days/1,000 Member Years—1–9 Years	—	—	—	—	—	—	39.66	38.43	42.21	21.95	46.78	NQ	**40.91**
Medicine—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	20.27	29.34	28.69	15.86	31.44	NQ	**27.72**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	117.49	117.80	100.58	73.77	119.05	NQ	**108.57**
Medicine—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	349.97	442.70	361.46	315.29	440.18	NQ	**393.48**
Medicine—Days/1,000 Member Years—65–74 Years	—	—	—	—	—	—	614.41	396.53	344.98	1,000.39	313.52	NQ	**550.81**
Medicine—Days/1,000 Member Years—75–84 Years	—	—	—	—	—	—	272.40	547.47	412.63	1,302.16	567.85	NQ	**921.88**
Medicine—Days/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	2,446.60	NA	455.36	2,008.39	389.03	NQ	**1,617.67**
Medicine—Days/1,000 Member Years—Total	—	—	—	—	—	—	142.36	137.61	132.55	99.99	129.83	NQ	**129.96**
Medicine—Discharges/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	65.78	78.27	74.93	60.70	82.28	NQ	**75.93**
Medicine—Discharges/1,000 Member Years—1–9 Years	—	—	—	—	—	—	9.27	11.42	12.08	7.37	13.50	NQ	**11.75**
Medicine—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	4.64	7.36	7.14	4.24	9.11	NQ	**7.45**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	22.06	26.16	20.98	15.51	26.84	NQ	**23.27**
Medicine—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	62.99	81.79	65.98	61.02	85.85	NQ	**73.88**
Medicine—Discharges/1,000 Member Years—65–74 Years	—	—	—	—	—	—	90.27	89.73	69.61	174.72	58.17	NQ	**99.37**
Medicine—Discharges/1,000 Member Years—75–84 Years	—	—	—	—	—	—	71.68	103.58	101.05	208.26	108.56	NQ	**158.65**
Medicine—Discharges/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	203.88	NA	107.14	186.24	89.78	NQ	**164.51**
Medicine—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	26.11	28.34	26.52	19.72	28.47	NQ	**26.76**
Medicine—Average Length of Stay—Less than 1 Year	—	—	—	—	—	—	7.06	5.71	5.35	6.68	4.86	NQ	**5.46**
Medicine—Average Length of Stay—1–9 Years	—	—	—	—	—	—	4.28	3.36	3.50	2.98	3.47	NQ	**3.48**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Average Length of Stay—10–19 Years	—	—	—	—	—	—	4.37	3.99	4.02	3.74	3.45	NQ	**3.72**
Medicine—Average Length of Stay—20–44 Years	—	—	—	—	—	—	5.33	4.50	4.79	4.76	4.43	NQ	**4.67**
Medicine—Average Length of Stay—45–64 Years	—	—	—	—	—	—	5.56	5.41	5.48	5.17	5.13	NQ	**5.33**
Medicine—Average Length of Stay—65–74 Years	—	—	—	—	—	—	6.81	4.42	4.96	5.73	5.39	NQ	**5.54**
Medicine—Average Length of Stay—75–84 Years	—	—	—	—	—	—	3.80	5.29	4.08	6.25	5.23	NQ	**5.81**
Medicine—Average Length of Stay—85 Years and Older	—	—	—	—	—	—	12.00	NA	4.25	10.78	4.33	NQ	**9.83**
Medicine—Average Length of Stay—Total	—	—	—	—	—	—	5.45	4.86	5.00	5.07	4.56	NQ	**4.86**
Total Inpatient—Days/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	1,035.71	763.24	771.07	689.3 2	1,016.28	NQ	**877.99**
Total Inpatient—Days/1,000 Member Years—1–9 Years	—	—	—	—	—	—	64.68	61.84	86.69	35.49	86.20	NQ	**74.37**
Total Inpatient—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	73.07	90.99	92.35	62.03	95.55	NQ	**88.24**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	370.41	368.44	346.00	289.95	401.50	NQ	**364.98**
Total Inpatient—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	723.27	804.21	690.66	661.57	821.22	NQ	**752.20**
Total Inpatient—Days/1,000 Member Years—65–74 Years	—	—	—	—	—	—	873.57	662.81	716.26	1,623.17	602.12	NQ	**944.52**
Total Inpatient—Days/1,000 Member Years—75–84 Years	—	—	—	—	—	—	888.89	1,242.91	1,583.16	2,352.21	1,219.21	NQ	**1,866.59**
Total Inpatient—Days/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	4,368.93	NA	455.36	2,557.05	897.76	NQ	**2,202.59**
Total Inpatient—Days/1,000 Member Years—Total	—	—	—	—	—	—	348.13	309.98	327.43	250.83	318.35	NQ	**315.49**
Total Inpatient—Discharges/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	88.07	95.75	93.18	74.28	105.73	NQ	**95.88**
Total Inpatient—Discharges/1,000 Member Years—1–9 Years	—	—	—	—	—	—	12.68	14.81	15.84	9.53	17.41	NQ	**15.29**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	15.80	21.48	22.91	16.62	23.43	NQ	**21.53**
Total Inpatient—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	80.08	92.43	87.86	76.38	105.67	NQ	**92.34**
Total Inpatient—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	106.13	125.44	106.87	102.99	132.34	NQ	**117.41**
Total Inpatient—Discharges/1,000 Member Years—65–74 Years	—	—	—	—	—	—	131.04	124.46	108.29	240.47	85.37	NQ	**141.53**
Total Inpatient—Discharges/1,000 Member Years—75–84 Years	—	—	—	—	—	—	129.03	177.56	160.00	315.67	175.37	NQ	**246.39**
Total Inpatient—Discharges/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	349.51	NA	107.14	236.58	149.63	NQ	**216.30**
Total Inpatient—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	61.55	62.98	66.65	51.53	66.27	NQ	**63.75**
Total Inpatient—Average Length of Stay—Less than 1 Year	—	—	—	—	—	—	11.76	7.97	8.28	9.28	9.61	NQ	**9.16**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Average Length of Stay—1–9 Years	—	—	—	—	—	—	4.63	4.23	4.03	3.73	4.95	NQ	**4.10**
Total Inpatient—Average Length of Stay—10–19 Years	—	—	—	—	—	—	5.10	4.18	5.47	3.72	4.08	NQ	**4.86**
Total Inpatient—Average Length of Stay—20–44 Years	—	—	—	—	—	—	4.63	3.99	3.94	3.80	3.80	NQ	**3.95**
Total Inpatient—Average Length of Stay—45–64 Years	—	—	—	—	—	—	6.81	6.41	6.46	6.42	6.21	NQ	**6.41**
Total Inpatient—Average Length of Stay—65–74 Years	—	—	—	—	—	—	6.67	5.33	6.61	6.75	7.05	NQ	**6.67**
Total Inpatient—Average Length of Stay—75–84 Years	—	—	—	—	—	—	6.89	7.00	9.89	7.45	6.95	NQ	**7.58**
Total Inpatient—Average Length of Stay—85 Years and Older	—	—	—	—	—	—	12.50	NA	4.25	10.81	6.00	NQ	**10.18**
Total Inpatient—Average Length of Stay—Total	—	—	—	—	—	—	5.66	4.92	4.91	4.87	4.80	NQ	**4.95**
Enrollment by Product Line													
Less than 1 year	—	—	—	—	—	—	2,691	5,150	7,727	3,460	11,905	8,498	**39,430**
1–4 Years	—	—	—	—	—	—	11,152	20,015	25,724	13,205	48,863	35,729	**154,688**
5–9 Years	—	—	—	—	—	—	14,314	23,939	29,593	17,315	61,390	48,063	**194,614**
10–14 Years	—	—	—	—	—	—	12,278	22,337	27,981	16,022	60,025	48,805	**187,448**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
15–17 Years	—	—	—	—	—	—	7,821	13,656	17,499	9,640	35,848	29,427	**113,890**
18–19 Years	—	—	—	—	—	—	4,714	8,181	10,822	5,918	20,567	16,987	**67,190**
20–24 Years	—	—	—	—	—	—	11,250	17,206	29,150	12,564	41,722	32,834	**144,726**
25–29 Years	—	—	—	—	—	—	11,619	13,753	29,039	10,160	30,569	24,721	**119,861**
30–34 Years	—	—	—	—	—	—	11,975	13,567	28,245	9,487	29,615	25,021	**117,909**
35–39 Years	—	—	—	—	—	—	10,415	11,853	23,917	7,835	25,187	22,937	**102,144**
40–44 Years	—	—	—	—	—	—	9,114	10,296	20,891	6,440	22,294	21,081	**90,116**
45–49 Years	—	—	—	—	—	—	7,249	8,036	15,779	4,579	17,049	16,300	**68,991**
50–54 Years	—	—	—	—	—	—	6,982	6,878	14,108	3,824	14,789	14,740	**61,320**
55–59 Years	—	—	—	—	—	—	7,116	7,176	13,439	3,629	14,718	14,428	**60,505**
60–64 Years	—	—	—	—	—	—	7,057	6,623	12,677	3,392	13,907	13,567	**57,221**
65–69 Years	—	—	—	—	—	—	261	267	507	692	1,161	507	**3,396**
70–74 Years	—	—	—	—	—	—	86	82	142	392	170	174	**1,046**
75–79 Years	—	—	—	—	—	—	46	38	67	277	74	90	**592**
80–84 Years	—	—	—	—	—	—	NA	NA	53	212	48	55	**421**
85–89 Years	—	—	—	—	—	—	NA	NA	NA	120	NA	NA	**224**
90 Years and Older	—	—	—	—	—	—	NA	NA	NA	105	NA	NA	**173**
Unknown	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
Total	—	—	—	—	—	—	136,199	189,108	307,397	129,267	449,932	374,001	**1,585,904**
Language Diversity of Membership													
Spoken Language Preferred for Health Care—Health Plan	—	—	—	—	—	—	0.00%	39.04%	100.00%	0.00%	0.00%	0.00%	**23.84%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Spoken Language Preferred for Health Care—CMS/State	—	—	—	—	—	—	100.00%	60.93%	0.00%	98.73%	99.91%	100.00%	**76.01%**
Spoken Language Preferred for Health Care—Other Third-Party	—	—	—	—	—	—	0.00%	0.04%	0.00%	1.27%	0.09%	0.00%	**0.15%**
Preferred Language for Written Materials—Health Plan	—	—	—	—	—	—	0.00%	38.51%	100.00%	0.00%	0.00%	0.00%	**23.78%**
Preferred Language for Written Materials—CMS/State	—	—	—	—	—	—	100.00%	61.45%	0.00%	98.73%	99.91%	0.00%	**52.79%**
Preferred Language for Written Materials—Other Third-Party	—	—	—	—	—	—	0.00%	0.04%	0.00%	1.27%	0.09%	100.00%	**23.43%**
Other Language Needs—Health Plan	—	—	—	—	—	—	0.00%	0.16%	100.00%	0.00%	0.00%	0.00%	**19.20%**
Other Language Needs—CMS/State	—	—	—	—	—	—	100.00%	99.79%	0.00%	0.00%	99.91%	0.00%	**47.96%**
Other Language Needs—Other Third-Party	—	—	—	—	—	—	0.00%	0.06%	0.00%	100.00%	0.09%	100.00%	**32.83%**
Spoken Language Preferred for Health Care—Percent English	—	—	—	—	—	—	0.00%	96.88%	98.00%	96.07%	98.36%	98.24%	**89.10%**
Spoken Language Preferred for Health Care—Percent Non-English	—	—	—	—	—	—	0.00%	3.05%	1.74%	2.66%	1.55%	1.76%	**1.78%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Spoken Language Preferred for Health Care—Percent Declined	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Spoken Language Preferred for Health Care—Percent Unknown	—	—	—	—	—	—	100.00%	0.07%	0.26%	1.27%	0.09%	0.00%	**9.12%**
Language Preferred for Written Materials—Percent English	—	—	—	—	—	—	0.00%	96.87%	98.00%	96.07%	98.36%	0.00%	**66.23%**
Language Preferred for Written Materials—Percent Non-English	—	—	—	—	—	—	0.00%	3.06%	1.74%	2.66%	1.55%	0.00%	**1.37%**
Language Preferred for Written Materials—Percent Declined	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Language Preferred for Written Materials—Percent Unknown	—	—	—	—	—	—	100.00%	0.07%	0.26%	1.27%	0.09%	100.00%	**32.40%**
Other Language Needs—Percent English	—	—	—	—	—	—	98.11%	98.17%	0.00%	0.00%	98.36%	0.00%	**47.18%**
Other Language Needs—Percent Non-English	—	—	—	—	—	—	1.84%	1.78%	0.00%	0.00%	1.55%	0.00%	**0.80%**
Other Language Needs—Percent Declined	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Other Language Needs—Percent Unknown	—	—	—	—	—	—	0.06%	0.06%	100.00%	100.00%	0.09 %	100.00%	**52.02%**
Race/Ethnicity Diversity of Membership													
Race—Health Plan	—	—	—	—	—	—	0.00%	35.80%	93.30%	0.00%	0.00%	0.00%	**22.17%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race—CMS/State	—	—	—	—	—	—	66.39%	53.72%	0.05%	35.56%	88.86%	72.12%	**56.65%**
Race—Other Direct	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.01%	1.59%	0.00%	**0.43%**
Race—Direct Total	—	—	—	—	—	—	66.39%	89.52%	93.35%	35.57%	90.44%	72.12%	**79.25%**
Race—Indirect Total	—	—	—	—	—	—	0.00%	0.00%	3.18%	0.00%	0.00%	0.00%	**0.61%**
Race—Unknown Total	—	—	—	—	—	—	33.61%	10.48%	3.47%	64.43%	9.56%	27.88%	**20.14%**
Ethnicity—Health Plan	—	—	—	—	—	—	0.00%	41.41%	92.20%	0.00%	0.00%	0.00%	**22.63%**
Ethnicity—CMS/State	—	—	—	—	—	—	72.75%	8.93%	0.00%	50.03%	2.16%	97.02%	**35.49%**
Ethnicity—Other Direct	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	8.10%	0.00%	**2.20%**
Ethnicity—Direct Total	—	—	—	—	—	—	72.75%	50.33%	92.20%	50.03%	10.26%	97.02%	**60.32%**
Ethnicity—Indirect Total	—	—	—	—	—	—	0.00%	0.00%	7.61%	0.00%	26.82%	0.00%	**8.74%**
Ethnicity—Unknown Total	—	—	—	—	—	—	27.25%	49.67%	0.19%	49.97%	62.92%	2.98%	**30.93%**
Race: White—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	4.05%	0.23%	0.00%	1.05%	0.00%	**0.81%**
Race: White—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	27.02%	14.51%	41.96%	32.62%	14.83%	37.91%	**28.15%**
Race: White—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.17%	0.02%	0.00%	0.00%	0.00%	**0.02%**
Race: White—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	16.51%	0.05%	0.45%	21.57%	0.00%	**7.88%**
Race: White—Ethnicity: Total	—	—	—	—	—	—	27.02%	35.24%	42.27%	33.07%	37.46%	37.91%	**36.87%**
Race: Black or African American—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	4.94%	0.07%	0.00%	0.26%	0.00%	**0.67%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	31.94%	21.23%	44.01%	0.01%	17.42%	29.32%	**25.38%**
Race: Black or African American—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.22%	0.01%	0.00%	0.00%	0.00%	**0.03%**
Race: Black or African American—Ethnicity: Unknown	—	—	—	—	—	—	0.14%	22.96%	0.03%	0.71%	30.74%	0.00%	**11.17%**
Race: Black or African American—Ethnicity: Total	—	—	—	—	—	—	32.08%	49.35%	44.12%	0.72%	48.41%	29.32%	**37.26%**
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.12%	0.01%	0.00%	0.04%	0.00%	**0.03%**
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.55%	0.30%	0.75%	0.00%	0.24%	0.80%	**0.48%**
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	0.35%	0.00%	0.63%	0.40%	0.00%	**0.21%**
Race: American Indian or Alaska Native—Ethnicity: Total	—	—	—	—	—	—	0.55%	0.78%	0.76%	0.63%	0.68%	0.80%	**0.72%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Asian—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.15%	0.07%	0.00%	0.02%	0.00%	**0.04%**
Race: Asian—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.46%	5.96%	0.00%	0.47%	1.10%	**1.58%**
Race: Asian—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asian—Ethnicity: Unknown	—	—	—	—	—	—	6.61%	0.77%	0.00%	1.14%	0.86%	0.00%	**1.02%**
Race: Asian—Ethnicity: Total	—	—	—	—	—	—	6.61%	1.38%	6.03%	1.14%	1.35%	1.10%	**2.64%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.02%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.03%	0.02%	0.00%	0.00%	0.01%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	—	—	—	—	—	—	0.03%	0.03%	0.00%	0.01%	0.01%	0.00%	**0.01%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	—	—	—	—	—	0.03%	0.08%	0.02%	0.01%	0.02%	0.01%	**0.02%**
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	0.22%	0.00%	0.38%	0.00%	**0.15%**
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	3.10%	0.00%	0.32%	0.00%	**0.68%**
Race: Some Other Race—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Some Other Race—Ethnicity: Unknown	—	—	—	—	—	—	0.11%	0.00%	0.01%	0.00%	1.80%	2.98%	**1.19%**
Race: Some Other Race—Ethnicity: Total	—	—	—	—	—	—	0.11%	0.00%	3.33%	0.00%	2.50%	2.98%	**2.02%**
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	1.21%	0.00%	0.00%	0.00%	0.00%	**0.14%**
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.14%	0.00%	0.00%	0.01%	0.00%	**0.02%**
Race: Two or More Races—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	**0.00%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Two or More Races—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	1.34%	0.00%	0.00%	0.02%	0.00%	**0.16%**
Race: Two or More Races—Ethnicity: Total	—	—	—	—	—	—	0.00%	2.70%	0.00%	0.00%	0.03%	0.00%	**0.33%**
Race: Unknown—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	1.63%	2.04%	0.35%	0.02%	0.62%	0.87%	**0.83%**
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.46%	0.68%	3.03%	0.00%	1.43%	27.01%	**7.38%**
Race: Unknown—Ethnicity: Asked but No Answer	—	—	—	—	—	—	11.14%	0.04%	0.00%	17.39%	0.00%	0.00%	**2.65%**
Race: Unknown—Ethnicity: Unknown	—	—	—	—	—	—	20.37%	7.72%	0.09%	47.02%	7.51%	0.00%	**9.27%**
Race: Unknown—Ethnicity: Total	—	—	—	—	—	—	33.61%	10.48%	3.47%	64.43%	9.56%	27.88%	**20.14%**
Race: Total—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	1.63%	12.53%	0.94%	0.02%	2.37%	0.87%	**2.67%**
Race: Total—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	59.97%	37.35%	98.83%	32.63%	34.71%	96.15%	**63.68%**
Race: Total—Ethnicity: Asked but No Answer	—	—	—	—	—	—	11.14%	0.45%	0.04%	17.39%	0.00%	0.00%	**2.71%**
Race: Total—Ethnicity: Unknown	—	—	—	—	—	—	27.25%	49.67%	0.19%	49.97%	62.92%	2.98%	**30.93%**
Race: Total—Ethnicity: Total	—	—	—	—	—	—	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Total	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	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.

Caution is recommended when comparing HUM's MY 2023 rates to the LDH target rates or other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

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

Measure Status	MY 2022					MY 2023*					
	ABH	ACLA	HBL	LHCC	UHC	ABH	ACLA	HBL	HUM	LHCC	UHC
≥ NCQA National 50th Percentile Benchmark	20	31	30	28	39	163	173	162	133	190	117
< NCQA National 50th Percentile Benchmark	58	47	48	50	39	113	94	112	132	85	67
NCQA National Benchmark Unavailable	11	11	11	11	11	12	12	12	12	12	12
Total	89	89	89	89	89	288	279	286	277	287	196

*The "Total" row presents the count of all HEDIS measure indicators that could be reported by the 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.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs' SWA 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 the MCOs, collectively, were effective in coordinating with providers to ensure adolescent and adult Medicaid members were properly screened for depression, enabling timely follow-up care. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure were above the NCQA national 50th percentile benchmark for MY 2023. Additionally, the rates of four MCOs (ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were 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]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were effective in ensuring that adult members with cardiovascular disease and schizophrenia had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Lead Screening in Children* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were 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]**
- The rates of three or more MCOs, as well as the SWA 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 the MCOs were effective in ensuring that children 2 years of age were receiving some immunizations to help protect them against a potential life-threatening disease. **[Quality and Access]**
- The rates of three or more MCOs, as well as the SWA 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 the MCOs were effective in ensuring that adolescent members were receiving immunizations to help protect them against meningococcal disease, tetanus, diphtheria, pertussis, and HPV. **[Quality]**

- The rates of all MCOs, as well as the SWA rate on the *Colorectal Cancer Screening* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Chlamydia Screening in Women—Total* measure indicator were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* measure indicator were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs 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]**
- The rates of five or more MCOs, as well as the SWA rate 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 the MCOs effectively coordinated with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- The rates of four MCOs (HBL, HUM, LHCC, UHC), as well as the SWA rate on the *Eye Exam for Patients With Diabetes* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to ensure that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- The rates of four MCOs (ABH, ACLA, HUM, LHCC), as well as the SWA rate on the *Pharmacotherapy for Opioid Use Disorder* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- The rates of all MCOs, as well as the SWA rate 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 the MCOs 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]**
- The rates of five MCOs (ABH, HBL, HUM, LHCC, UHC), as well as the SWA rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- The rates of four MCOs (ABH, ACLA, HBL, UHC), as well as the SWA rate on the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure

indicator were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs 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]**

- The rates of four MCOs (ABH, ACLA, HBL, LHCC), as well as the SWA rate 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 the MCOs effectively coordinated with providers to help members with persistent asthma manage this treatable condition. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate 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 the MCOs 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]**
- The rates of three MCOs (ACLA, LHCC, UHC), as well as the SWA rate 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 these MCOs effectively coordinated with providers to ensure that adolescent members received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- The rates of all MCOs, as well as the SWA rate 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 the MCOs have 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]**
- The rates of all MCOs, as well as the SWA rate 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, the rates of all MCOs, as well as the SWA rate 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 the MCOs have room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**

- The rates of three or more MCOs, as well as the SWA rate 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 the MCOs have room for improvement in their coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- The rates of three or more MCOs, as well as the SWA rate 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 the MCOs have 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]**
- The rates of five or more MCOs, as well as the SWA rate 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 the MCOs have room for improvement in their coordination 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]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Controlling High Blood Pressure* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- The rates of four MCOs (ACLA, HBL, HUM, UHC), as well as the SWA rate on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that MCOs have room for improvement in coordinating with providers to ensure that members with ASCVD adhere to statin therapy to effectively manage their condition. **[Quality]**
- The rates of four MCOs (ABH, ACLA, HBL, LHCC), as well as the SWA rate on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have 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]**
- The rates of three MCOs (ABH, HBL, LHCC), as well as the SWA rate on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator were below the NCQA

national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to initiate appropriate follow-up visits for children prescribed ADHD medication. **[Quality, Timeliness, and Access]**

- The rates of four or more MCOs, as well as the SWA rate 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 the MCOs have 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]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that a diagnosis of upper respiratory infection (URI) does not result in an antibiotic dispensing event for members. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have 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]**
- The rates of all MCOs, as well as the SWA rate on the *Use of Imaging Studies for Low Back Pain* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that MCOs have room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Non-Recommended Cervical Screening in Adolescent Females* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that providers avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, HUM, UHC), as well as the SWA rate on the *Cervical Cancer Screening* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure that women ages 21 to 64 years receive appropriate, early detection cancer screening. **[Quality]**
- The rates of four MCOs, as well as the SWA rate 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 the MCOs have 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]**
- The rates of five of more MCOs, as well as the SWA rate 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 the MCOs have 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 AAP and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**

For the MCOs statewide, 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 the MCOs 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 the MCOs. The MCOs 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 the MCOs work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators, HSAG recommends that the MCOs 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 the MCOs focus their efforts on increasing immunizations for children. The MCOs 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, the MCOs 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 the MCOs 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. The MCOs 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 the MCOs work with providers to identify and address barriers to effective blood pressure management in members. The MCOs 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, the MCOs 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 the MCOs work with providers to identify and address barriers to statin therapy adherence among members with ASCVD. The MCOs 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 *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure, HSAG recommends that the MCOs work with providers to identify and address barriers to effective blood pressure management for diabetic members. HSAG also recommends that the MCOs 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. The MCOs 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 *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that the MCOs 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. The MCOs 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 *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator, HSAG recommends that the MCOs work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. The MCOs 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, Timeliness, and Access]**
- To improve performance on the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators, HSAG recommends that the MCOs 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. The MCOs 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 education and offering telehealth services. **[Quality]**

- To improve performance on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce antibiotic dispensing to treat URIs. The MCOs 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 the MCOs work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. The MCOs 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 the MCOs focus their efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that the MCOs 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 the MCOs 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 the MCOs work with providers to identify and address barriers to cervical cancer screening for women ages 21 to 64 years old. The MCOs 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 the MCOs work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. The MCOs 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 the MCOs work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. HSAG recommends the MCOs 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]**

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 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 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 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.

[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.

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, MRRV 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 Health Maintenance Organization (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 2023 performance levels based on comparison to the NCQA national 50th percentile benchmark 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*	✓		✓
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

Performance Measure	Quality	Timeliness	Access
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*	✓		
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	✓		

Performance Measure	Quality	Timeliness	Access
Use of Imaging Studies for Low Back Pain	✓		
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*	✓		
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

Aggregate 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 each MCO.

Table 4-1—Summary of CR Scores for the Three-Year Review Period: CY 2021–CY 2023[1,2,3]

Standard Name	ABH			ACLA			HBL			LHCC			UHC		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Enrollment and Disenrollment[2]		**42.9%**			**100%**			**71.4%**			**85.7%**			**85.7%**	
Member Rights and Confidentiality	93.0%			99.1%			99.1%			99.1%			99.5%		
Member Information															
Coverage and Authorization of Services	98.5%			99.2%			100%			99.2%			100%		
Emergency and Post-Stabilization Services															
Availability of Services	99.2%			95.0%			99.6%			100%			98.8%		
Assurances of Adequate Capacity and Services	100%			100%			100%			100%			100%		
Coordination and Continuity of Care	91.6%			95.2%			100%			91.0%			90.7%		
Provider Selection	97.8%			100%			97.8%			100%			97.8%		
Subcontractual Relationships and Delegation	100%			100%			100%			100%			100%		
Practice Guidelines	100%			100%			100%			100%			100%		
Health Information Systems	100%			100%			100%			100%			100%		
Quality Assessment and Performance Improvement Program	98.6%			98.6%			100%			100%			100%		

Standard Name	ABH			ACLA			HBL			LHCC			UHC		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Grievance and Appeal Systems	100%			100%			99.3%			100%			100%		
Program Integrity	95.8%			100%			100%			94.6%			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*.

[3] HUM was excluded from this results summary as it was a new MCO to the Louisiana market as of January 2023; therefore, HUM was not subject to the CR.

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.

The MCOs achieved compliance in 14 of 14 elements 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.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs successfully remediated all 14 elements, indicating that initiatives were implemented and demonstrated compliance with the requirements under review. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- HSAG did not identify any opportunities for improvement.

For the MCOs statewide, the following recommendations were identified:

- HSAG did not identify any required actions or recommendations.

Methodology

Standards

Table 4-2 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In year three (CY 2023), HSAG conducted a follow-up review of each MCO's CAPs from the previous CR. 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	✓	✓	✓						
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[1,2]

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56 42 CFR §438.608	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).

[2] Note that in year one, the previous EQRO utilized a different numbering system for the standards.

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.

[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:
	• 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 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	✓		
Standard XIII—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Program Integrity	✓	✓	✓

5. Validation of Network Adequacy

Aggregate Results

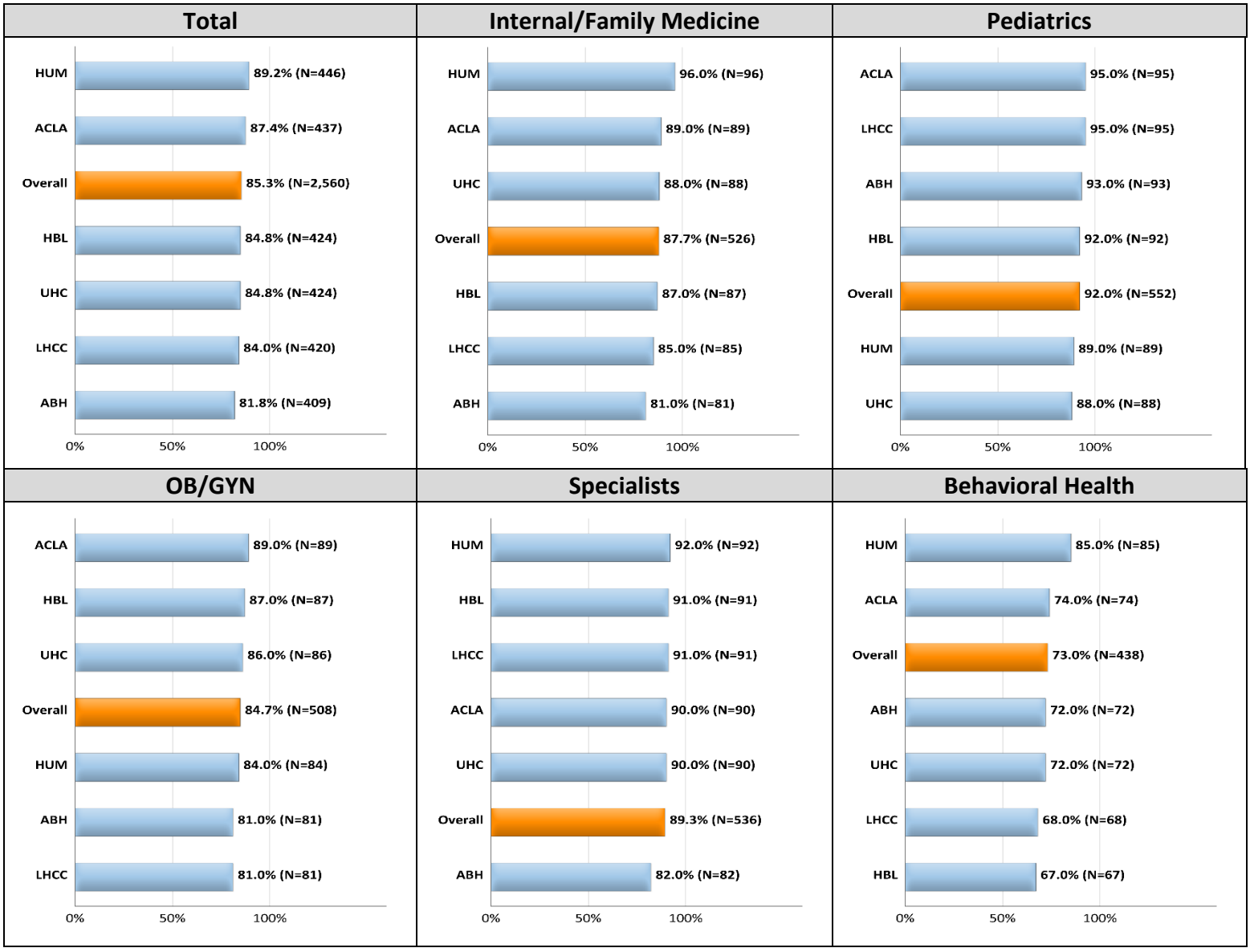
Provider Directory Accuracy

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 providers by MCO and specialty type across all four quarters.

Response Rate

Figure 5-1 illustrates the survey disposition and response rates by MCO and specialty type.

Figure 5-1—PDV Response Rates by MCO and Specialty Type



Correct Address

Figure 5-2 displays the percentage of cases in which the survey respondent reported that the MCOs' provider directory reflected the correct address.

Figure 5-2—Respondents With the Correct Address

Provider at Correct Location

Figure 5-3 displays the percentage of cases in which the survey respondent confirmed that the sampled provider was at the location.

Figure 5-3—Respondents That Confirmed Sampled Provider at Correct Location

Specialty

Figure 5-4 displays the percentage of cases in which the survey respondent confirmed that the sampled provider was the specialty indicated in the MCO's provider directory.

Figure 5-4—Respondents That Confirmed Provider Specialty

Acceptance Rates

Figure 5-5 through Figure 5-7 display the percentage of cases in which the survey respondent confirmed the provider accepted the requested MCO, Louisiana Medicaid, and new patients, respectively.

Figure 5-5—Respondents That Confirmed the Provider Accepted the MCO

Figure 5-6—Respondents That Confirmed the Provider Accepted Louisiana Medicaid

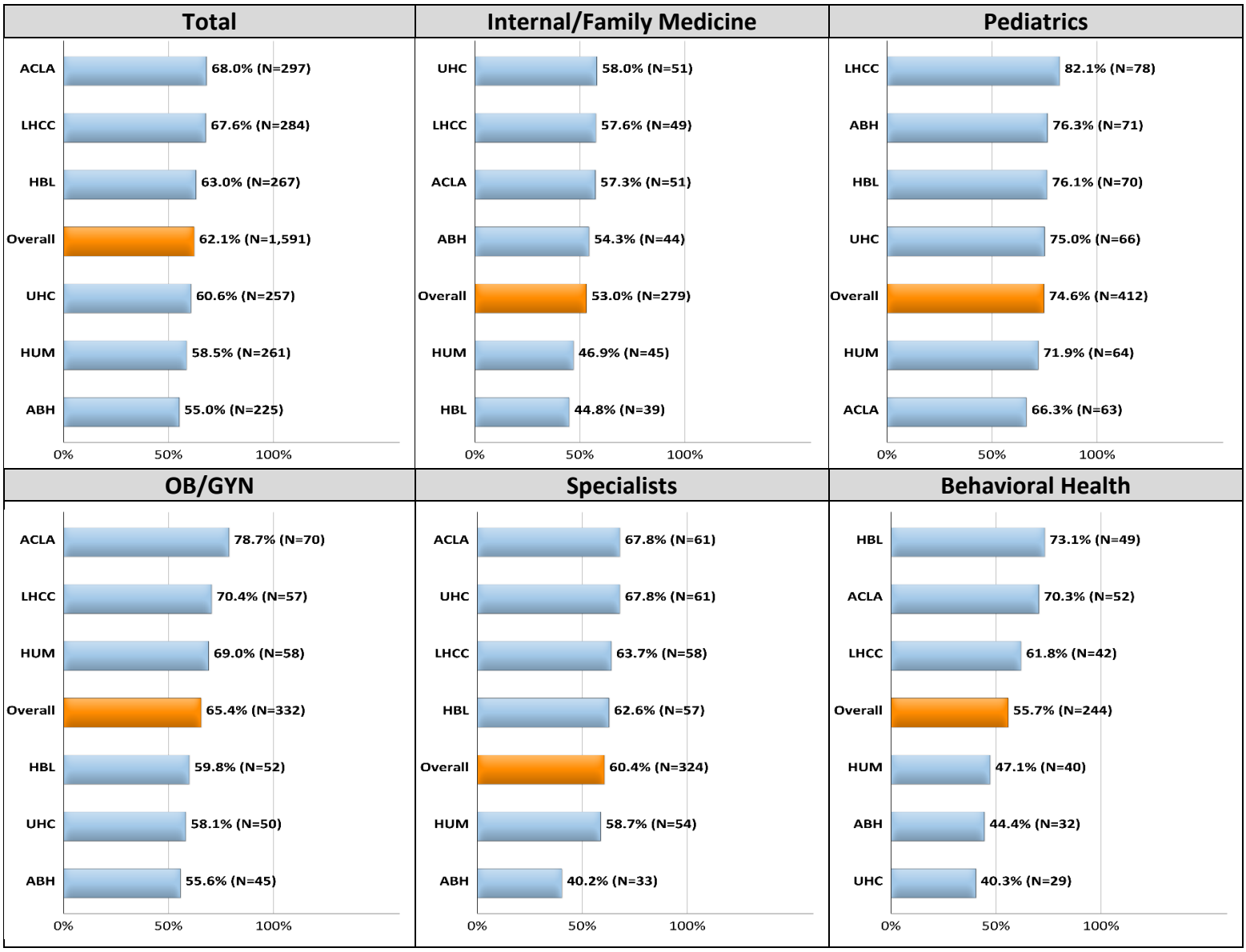


Figure 5-7—Respondents That Confirmed the Provider Accepted New Patients

Compliance Scores

Table 5-1 and Table 5-2 present the PDV weighted compliance scores by specialty type and MCO, respectively.

Table 5-1—PDV Weighted Compliance Scores by Specialty Type

Specialty	Total	Compliant[1]	Weighted Compliance Score
Overall	**3,000**	**1,107**	**44.2%**
Internal Medicine/Family Medicine	600	188	39.0%
Pediatrics	600	313	59.1%
OB/GYN	600	216	46.4%
Specialists (any)	600	233	45.0%
Behavioral Health (any)	600	157	31.2%

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

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

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Overall	**3,000**	**1,107**	**44.2%**
ABH	**500**	**122**	**34.8%**
Internal Medicine/Family Medicine	100	21	35.0%
Pediatrics	100	40	54.3%
OB/GYN	100	22	35.0%
Specialists (any)	100	19	24.3%
Behavioral Health (any)	100	20	25.3%
ACLA	**500**	**225**	**50.8%**
Internal Medicine/Family Medicine	100	34	40.7%
Pediatrics	100	46	53.3%
OB/GYN	100	57	64.0%
Specialists (any)	100	47	52.0%
Behavioral Health (any)	100	41	44.0%
HBL	**500**	**175**	**43.5%**
Internal Medicine/Family Medicine	100	27	34.3%
Pediatrics	100	53	60.3%
OB/GYN	100	32	44.0%

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Specialists (any)	100	37	46.3%
Behavioral Health (any)	100	26	32.3%
HUM	**500**	**185**	**42.9%**
Internal Medicine/Family Medicine	100	33	37.7%
Pediatrics	100	49	53.7%
OB/GYN	100	42	51.0%
Specialists (any)	100	35	41.0%
Behavioral Health (any)	100	26	31.0%
LHCC	**500**	**211**	**50.0%**
Internal Medicine/Family Medicine	100	35	42.7%
Pediatrics	100	69	73.0%
OB/GYN	100	37	50.0%
Specialists (any)	100	45	52.0%
Behavioral Health (any)	100	25	32.3%
UHC	**500**	**189**	**43.0%**
Internal Medicine/Family Medicine	100	38	43.7%
Pediatrics	100	56	60.0%
OB/GYN	100	26	34.7%
Specialists (any)	100	50	54.3%
Behavioral Health (any)	100	19	22.3%

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

Table 5-3 presents the reasons for noncompliance.

Table 5-3—Reasons for Noncompliance

Reason	ABH	ACLA	HBL	HUM	LHCC	UHC	Total
Noncompliant providers	**75.6% (378)**	**55.0% (275)**	**65.0% (325)**	**63.0% (315)**	**57.8% (289)**	**62.2% (311)**	**63.1% (1,893)**
Total reasons for noncompliance[1]	**441**	**325**	**397**	**378**	**332**	**372**	**2,245**
Provider does not participate with MCO or Louisiana Medicaid	9.6% (48)	12.2% (61)	17.2% (86)	24.2% (121)	16.0% (80)	22.4% (112)	16.9% (508)
Provider is not at site	21.4% (107)	15.4% (77)	12.4% (62)	13.4% (67)	8.0% (40)	10.0% (50)	13.4% (403)

Reason	ABH	ACLA	HBL	HUM	LHCC	UHC	Total
Provider not accepting new patients	4.4% (22)	4.8% (24)	6.8% (34)	8.2% (41)	5.2% (26)	7.6% (38)	6.2% (185)
Wrong telephone number	0.8% (4)	0.2% (1)	1.0% (5)	0.4% (2)	0.4% (2)	0.4% (2)	0.5% (16)
No response/busy signal/disconnected telephone number (after three calls)	17.0% (85)	11.6% (58)	14.2% (71)	9.8% (49)	15.6% (78)	14.6% (73)	13.8% (414)
Representative does not know	0.2% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (1)
Incorrect address reported	23.2% (116)	13.8% (69)	14.0% (70)	11.6% (58)	8.6% (43)	12.0% (60)	13.9% (416)
Address (suite number) needs to be updated	3.8% (19)	2.8% (14)	3.8% (19)	2.2% (11)	3.2% (16)	1.6% (8)	2.9% (87)
Wrong specialty reported	7.8% (39)	4.2% (21)	10.0% (50)	5.8% (29)	9.4% (47)	5.8% (29)	7.2% (215)

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.

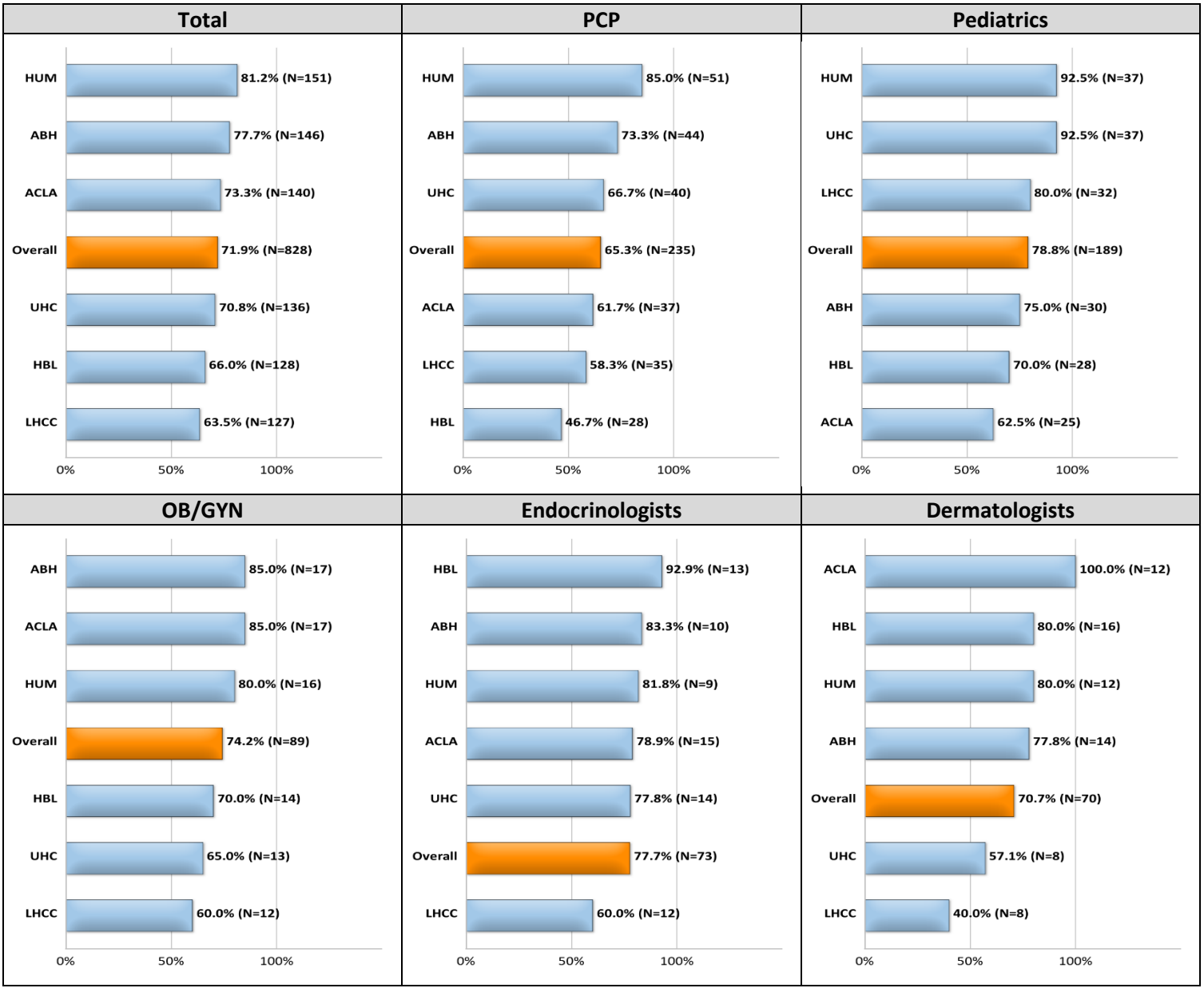
Provider Access Surveys

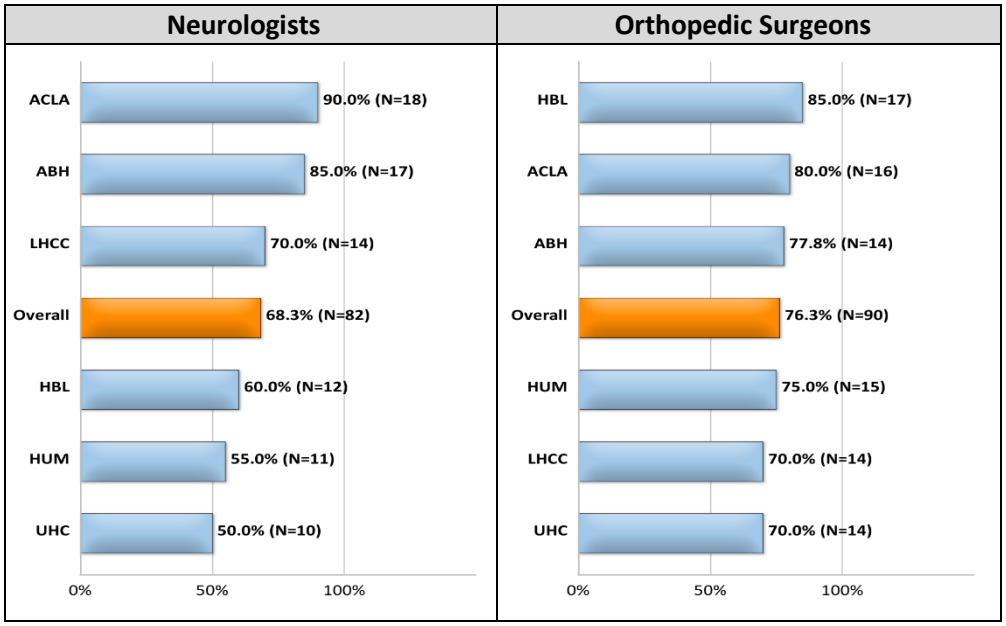
HSAG conducted provider access surveys in September 2023 and November to December 2023 (review period). This section presents the results from the CY 2023 provider access surveys for all sampled providers by MCO and specialty type.

Response Rate

Figure 5-8 illustrates the provider access survey response rates by MCO and specialty type.

Figure 5-8—Provider Access Survey Response Rates by MCO and Specialty Type

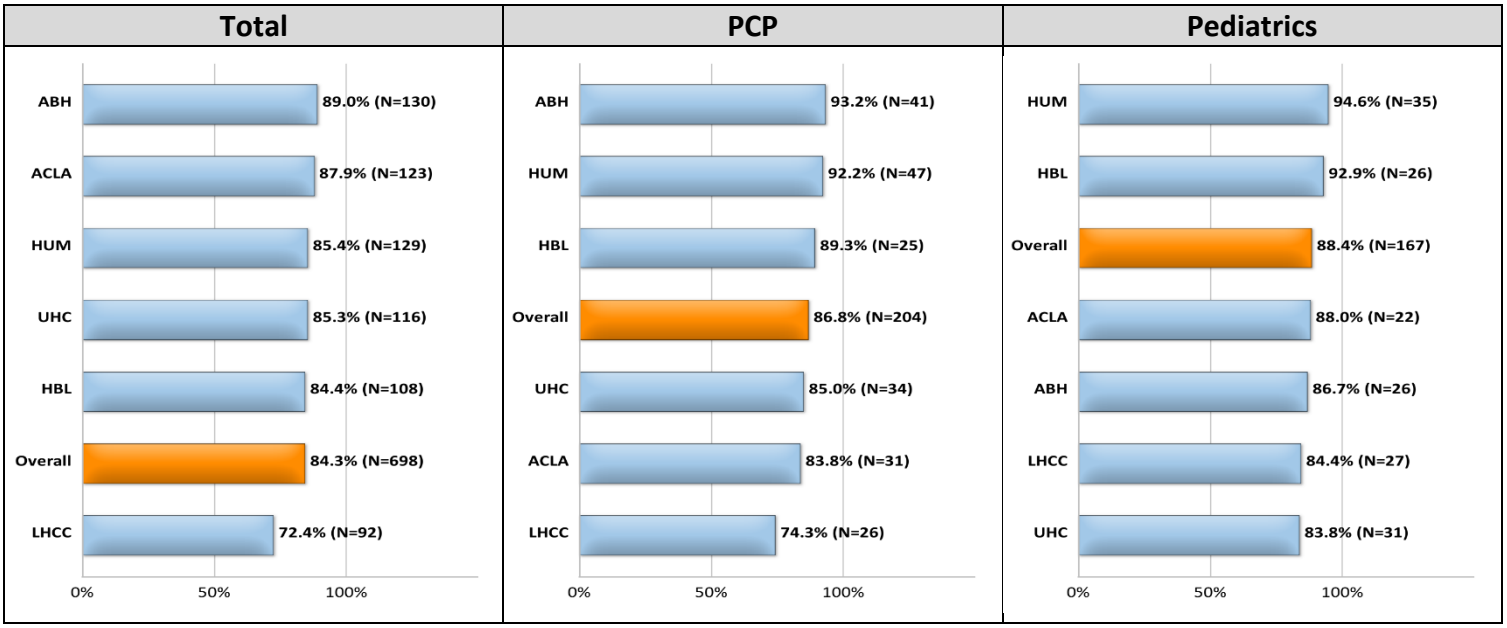


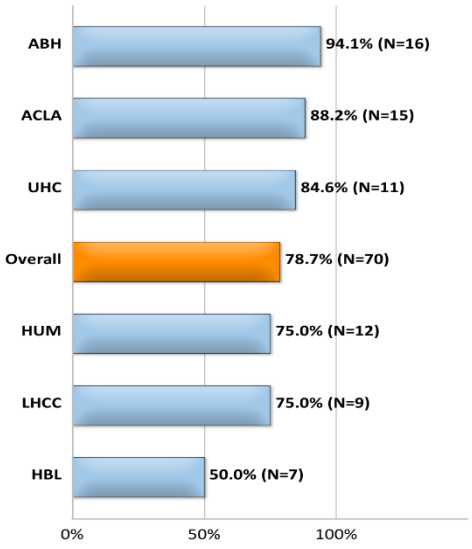
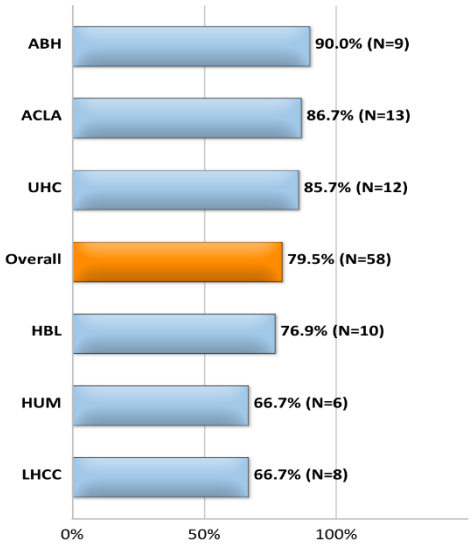
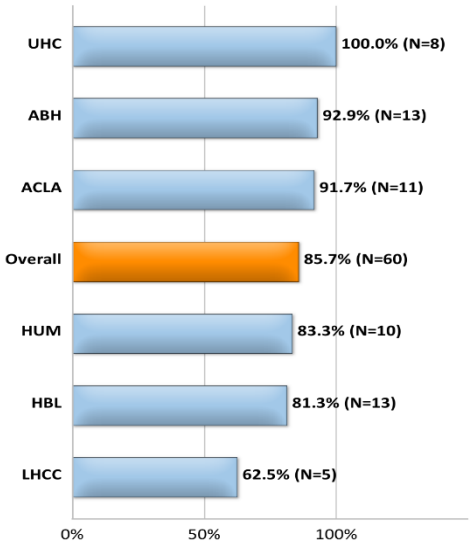


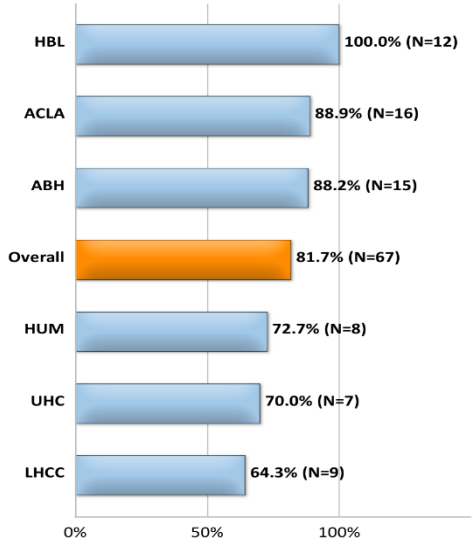
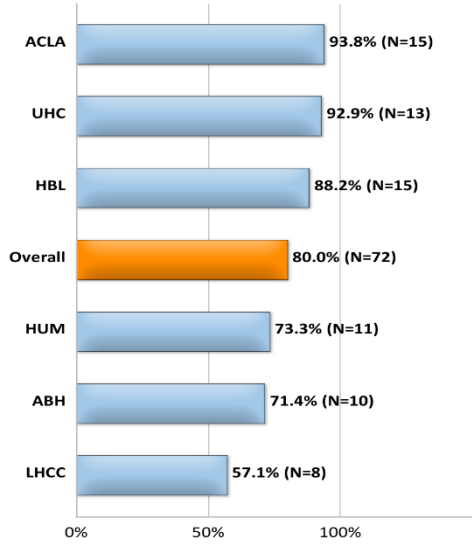
Correct Address

Figure 5-9 displays the percentage of cases in which the provider access survey respondent reported that the MCOs' provider data reflected the correct address.

Figure 5-9—Provider Access Survey Respondents With the Correct Address



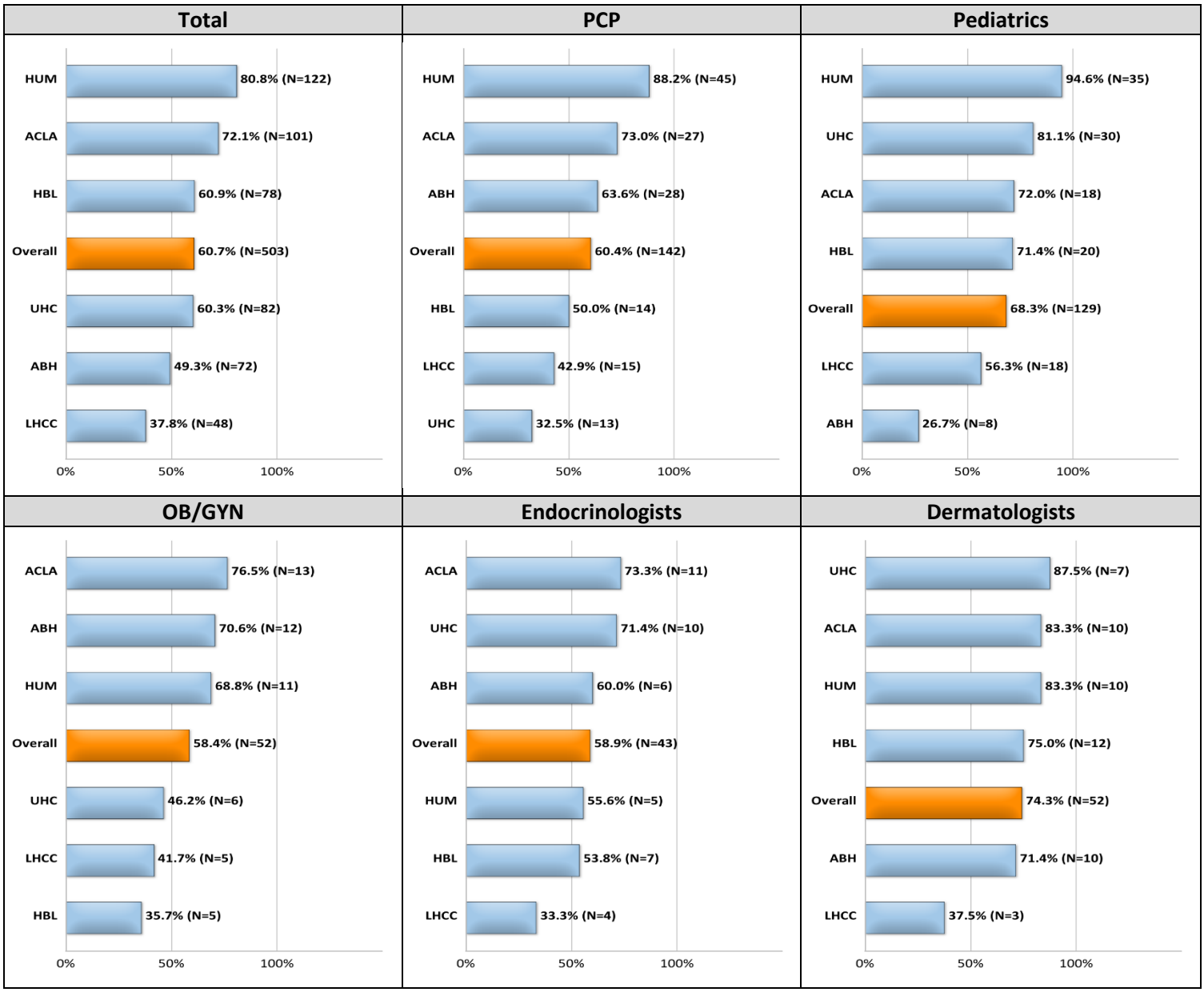
OB/GYN	Endocrinologists	Dermatologists
		

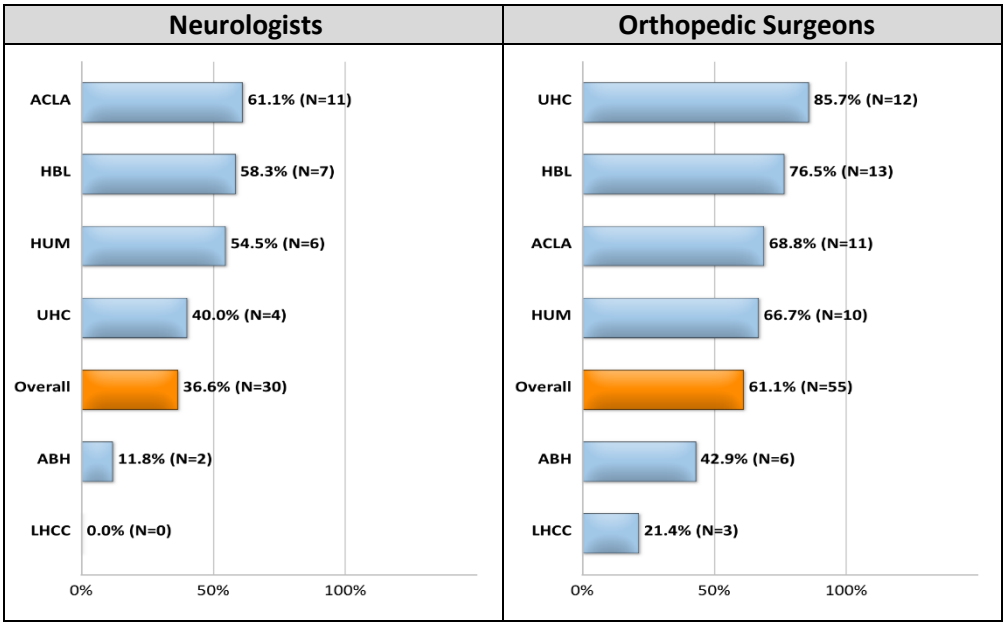
Neurologists	Orthopedic Surgeons
	

Offered Requested Services

Figure 5-10 displays the percentage of cases in which the provider access survey respondent confirmed that the sampled location offered the requested services.

Figure 5-10—Provider Access Survey Locations That Offered the Requested Services

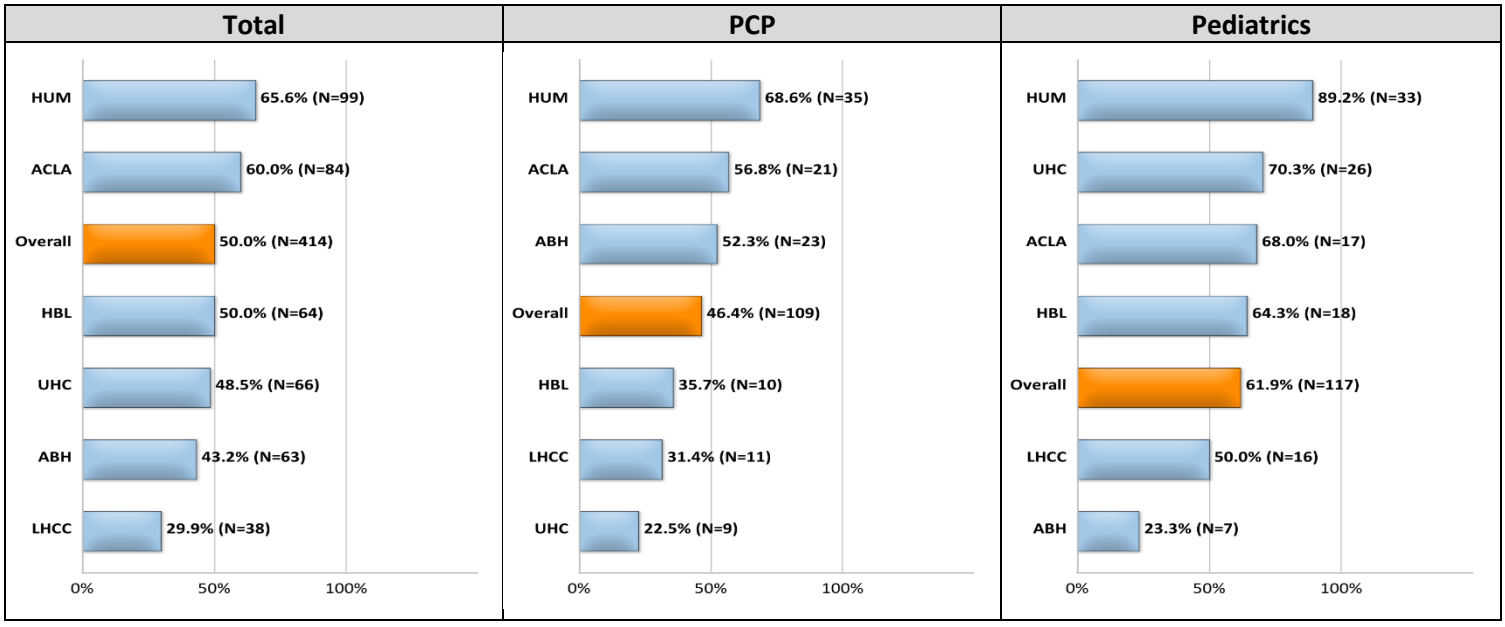


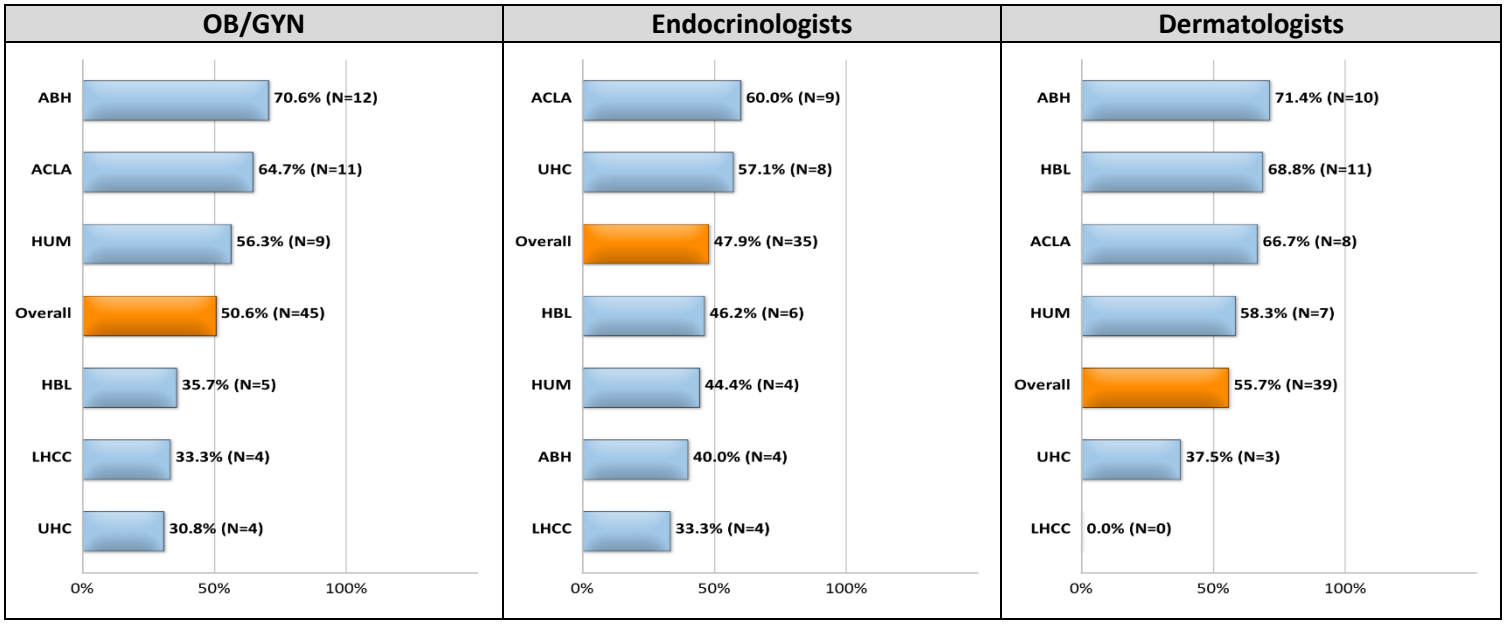


Acceptance Rates

Figure 5-11 through Figure 5-13 display the percentage of cases in which the provider access survey respondent confirmed the location accepted the requested MCO, Louisiana Medicaid, and new patients, respectively.

Figure 5-11—Provider Access Survey Respondents That Confirmed the Location Accepted the MCO




OB/GYN
ABH 70.6% (N=12)
ACLA 64.7% (N=11)
HUM 56.3% (N=9)
Overall 50.6% (N=45)
HBL 35.7% (N=5)
LHCC 33.3% (N=4)
UHC 30.8% (N=4)
0% 50% 100%
Endocrinologists
ACLA 60.0% (N=9)
UHC 57.1% (N=8)
Overall 47.9% (N=35)
HBL 46.2% (N=6)
HUM 44.4% (N=4)
ABH 40.0% (N=4)
LHCC 33.3% (N=4)
0% 50% 100%
Dermatologists
ABH 71.4% (N=10)
HBL 68.8% (N=11)
ACLA 66.7% (N=8)
HUM 58.3% (N=7)
Overall 55.7% (N=39)
UHC 37.5% (N=3)
LHCC 0.0% (N=0)
0% 50% 100%

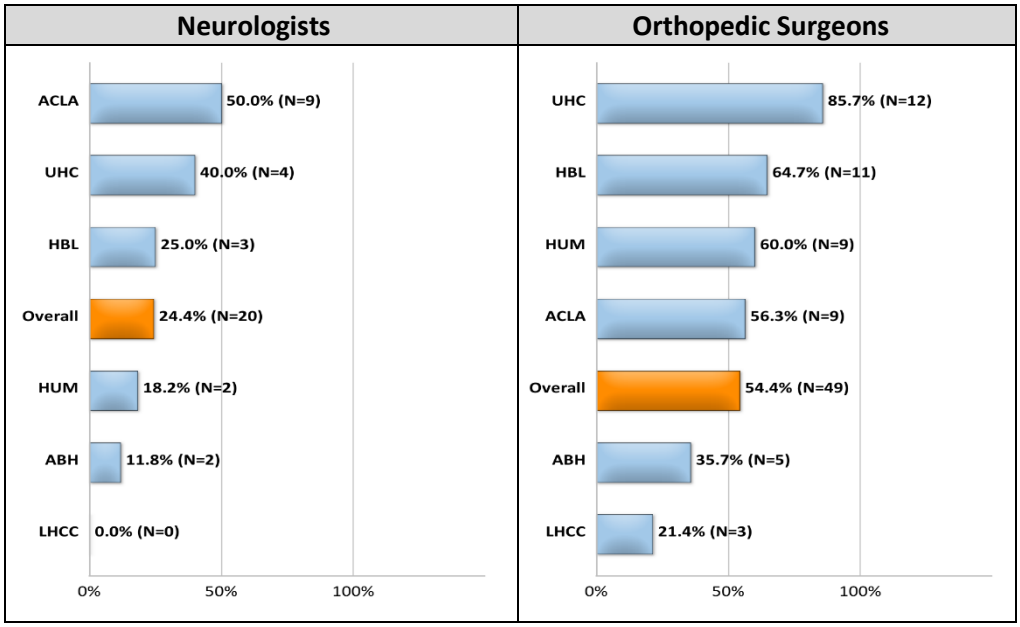
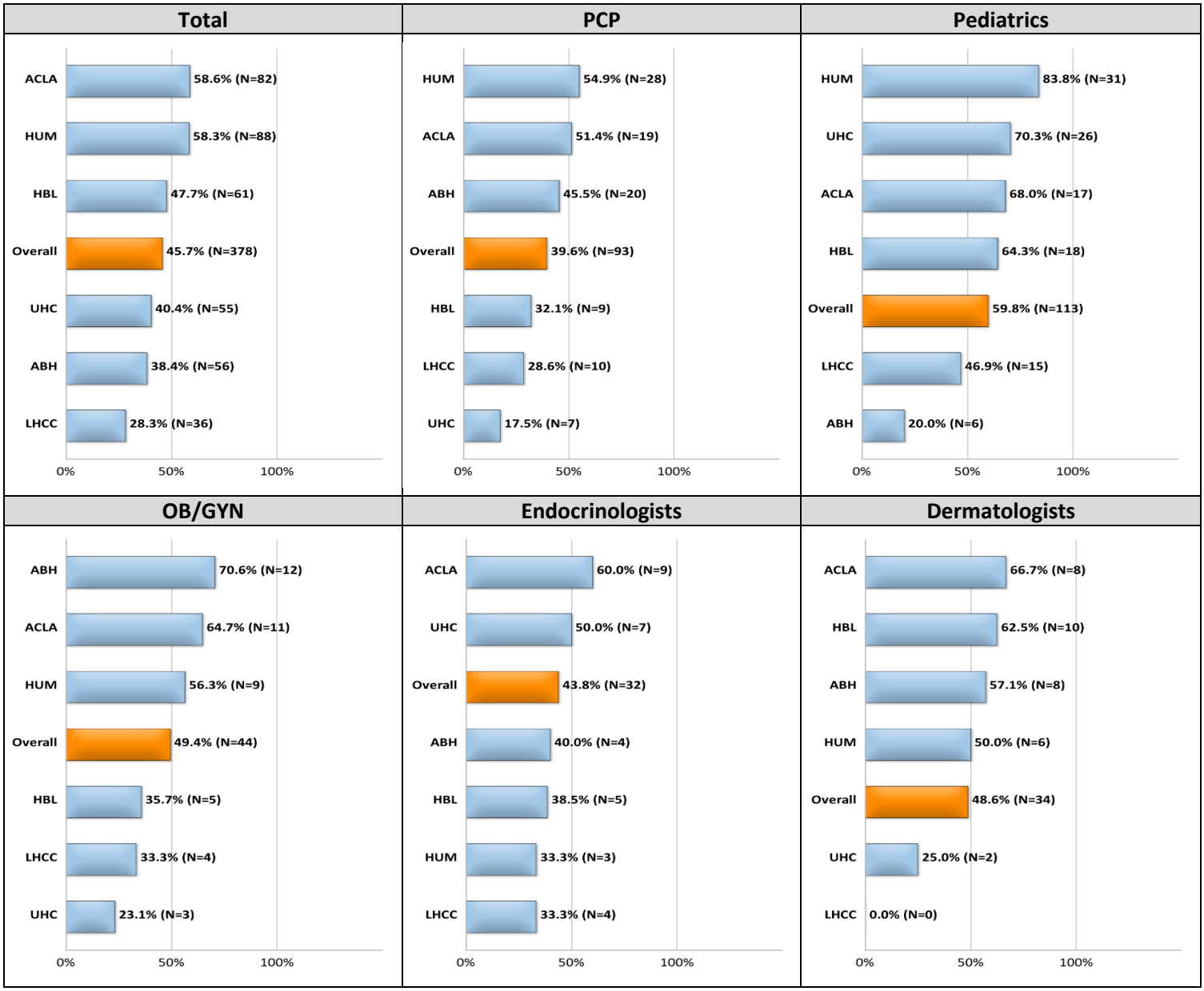

Neurologists
ACLA 50.0% (N=9)
UHC 40.0% (N=4)
HBL 25.0% (N=3)
Overall 24.4% (N=20)
HUM 18.2% (N=2)
ABH 11.8% (N=2)
LHCC 0.0% (N=0)
0% 50% 100%
Orthopedic Surgeons
UHC 85.7% (N=12)
HBL 64.7% (N=11)
HUM 60.0% (N=9)
ACLA 56.3% (N=9)
Overall 54.4% (N=49)
ABH 35.7% (N=5)
LHCC 21.4% (N=3)
0% 50% 100%

Figure 5-12—Provider Access Survey Respondents That Confirmed the Location Accepted Louisiana Medicaid



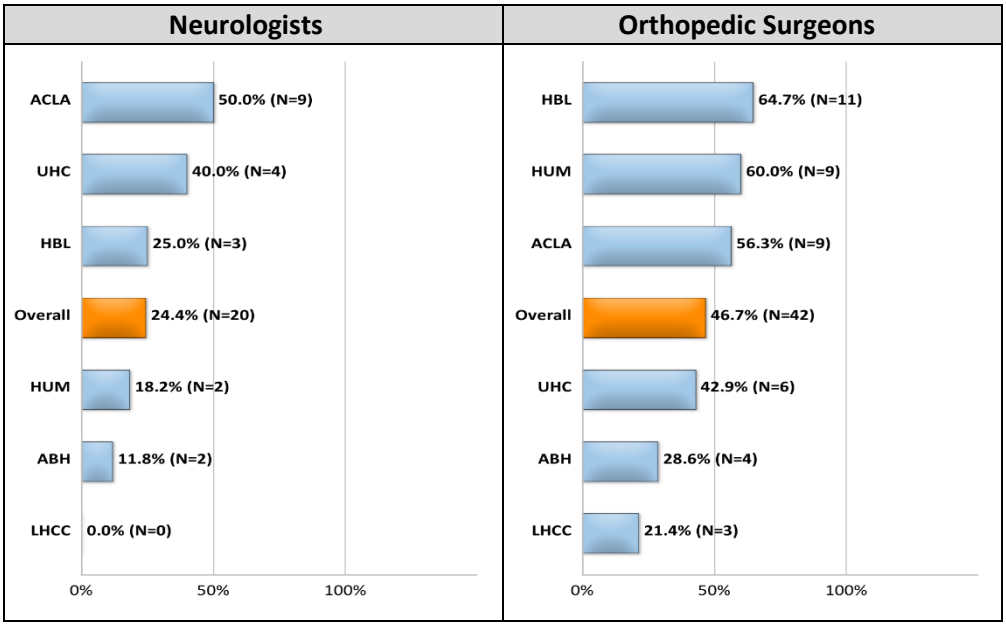
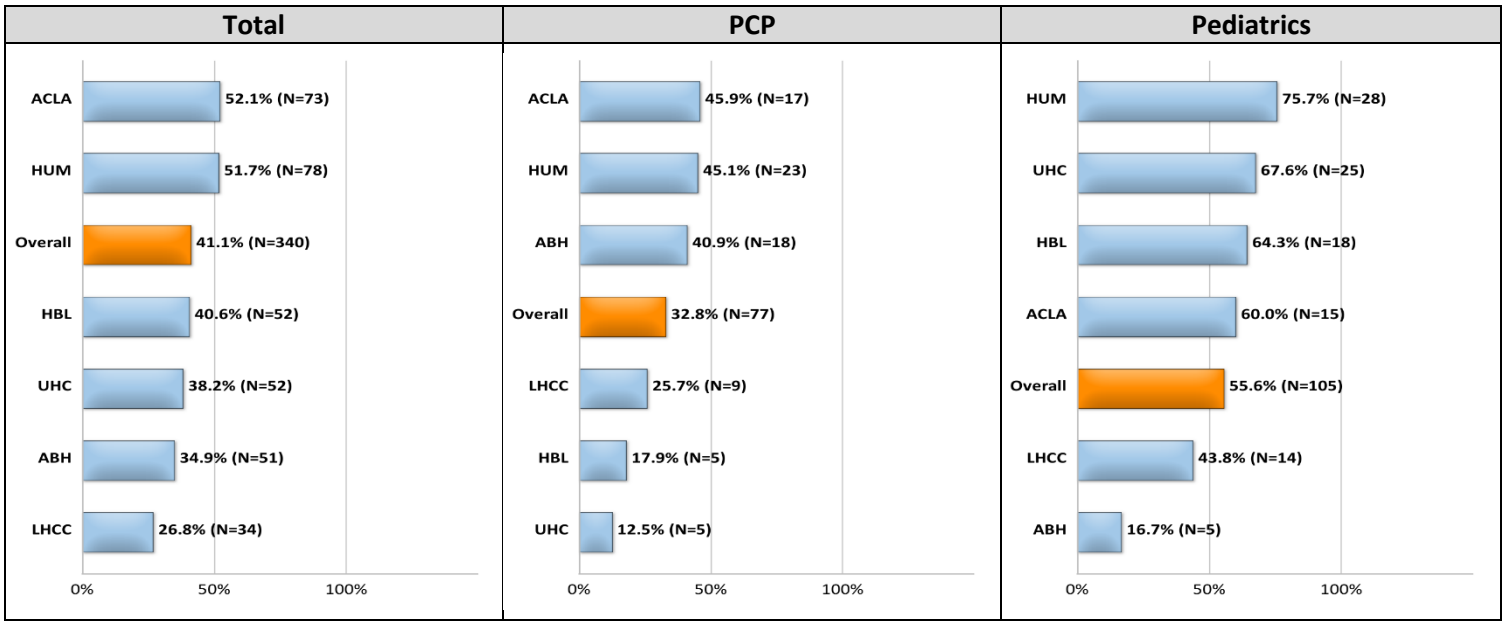
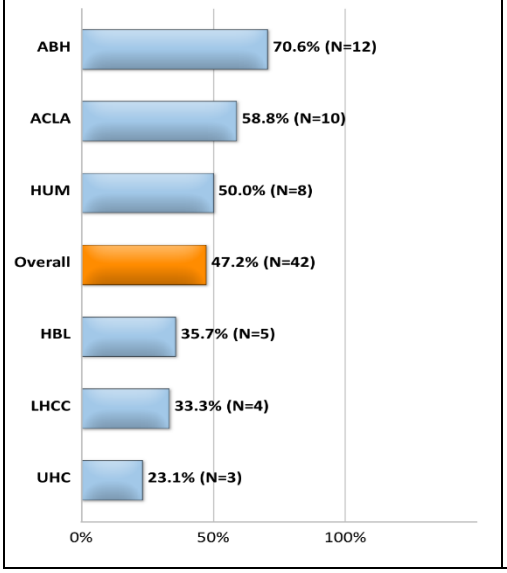


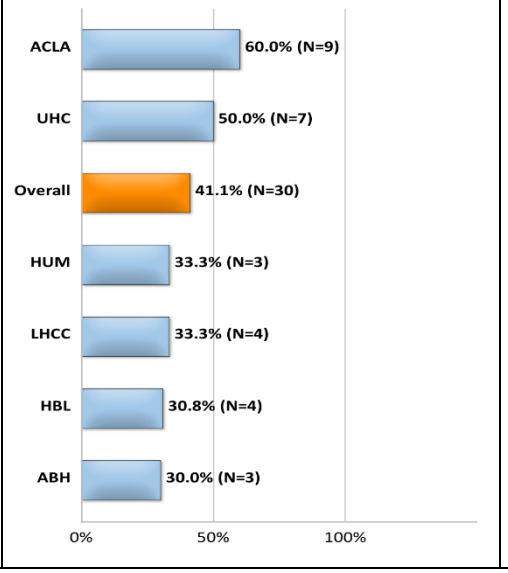
Figure 5-13—Provider Access Survey Respondents That Confirmed the Location Accepted New Patients



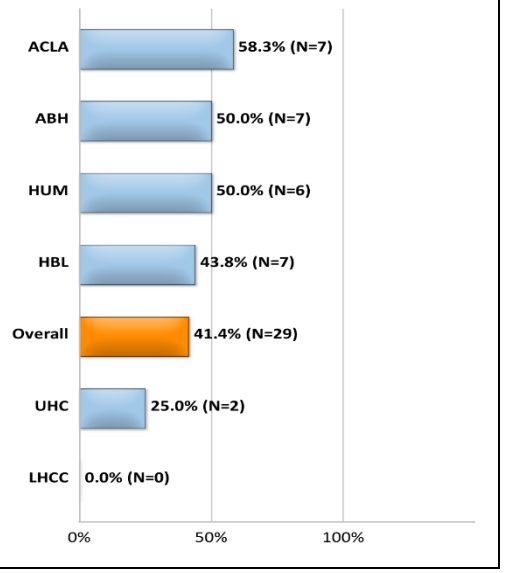
OB/GYN



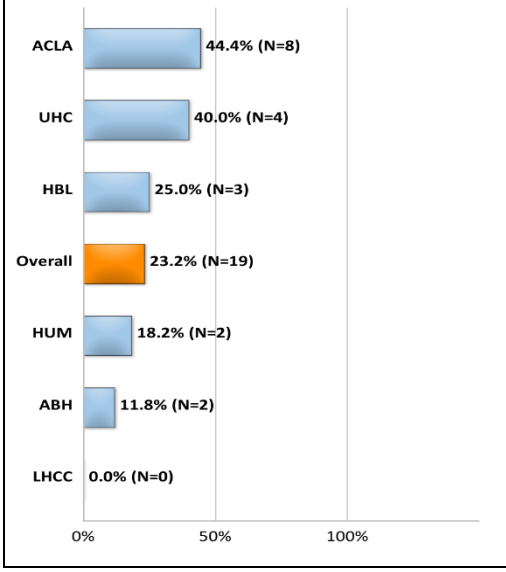
Endocrinologists



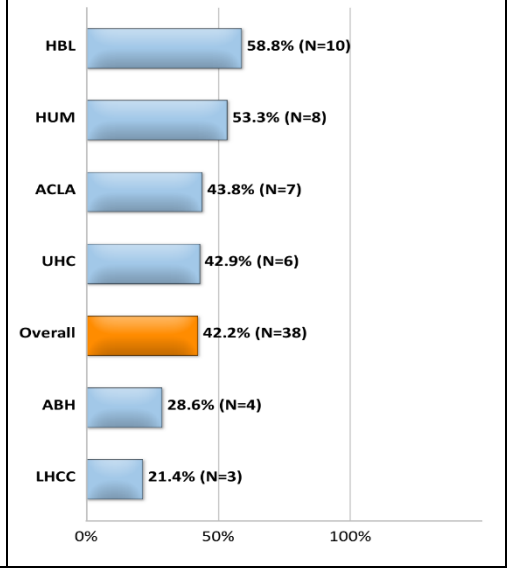
Dermatologists



Neurologists



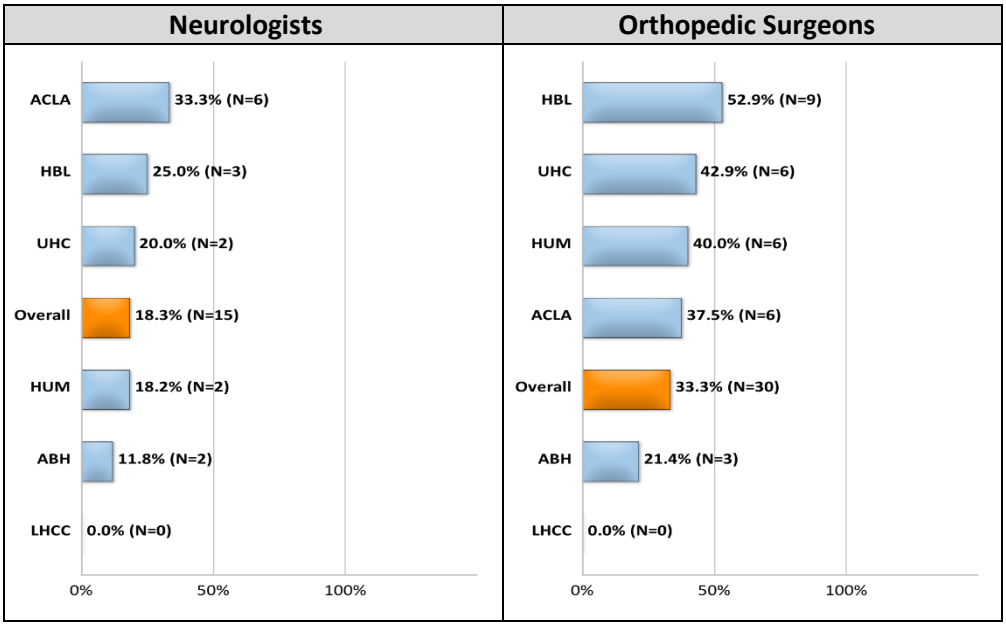
Orthopedic Surgeons



Provider at Correct Location

Figure 5-14 displays the percentage of cases in which the provider access survey respondent confirmed that the sampled provider was at the location.

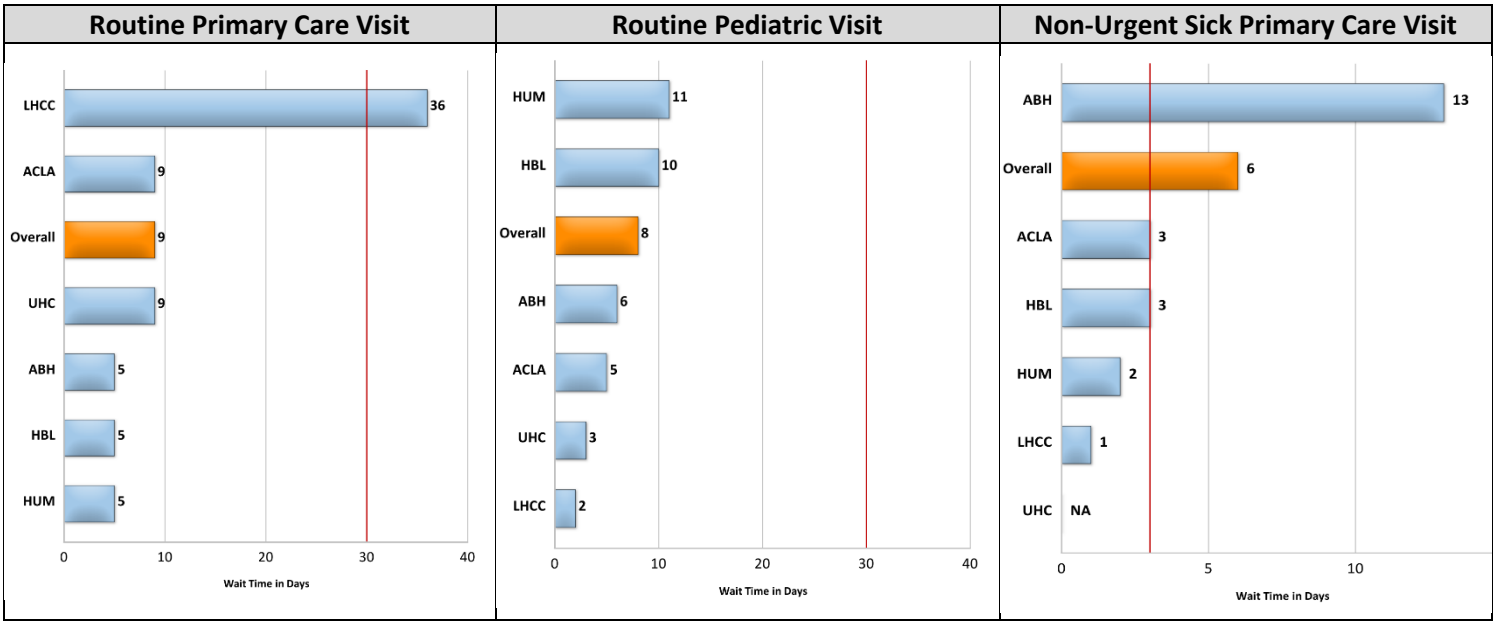
Figure 5-14—Provider Access Survey Respondents That Confirmed Sampled Provider at Location

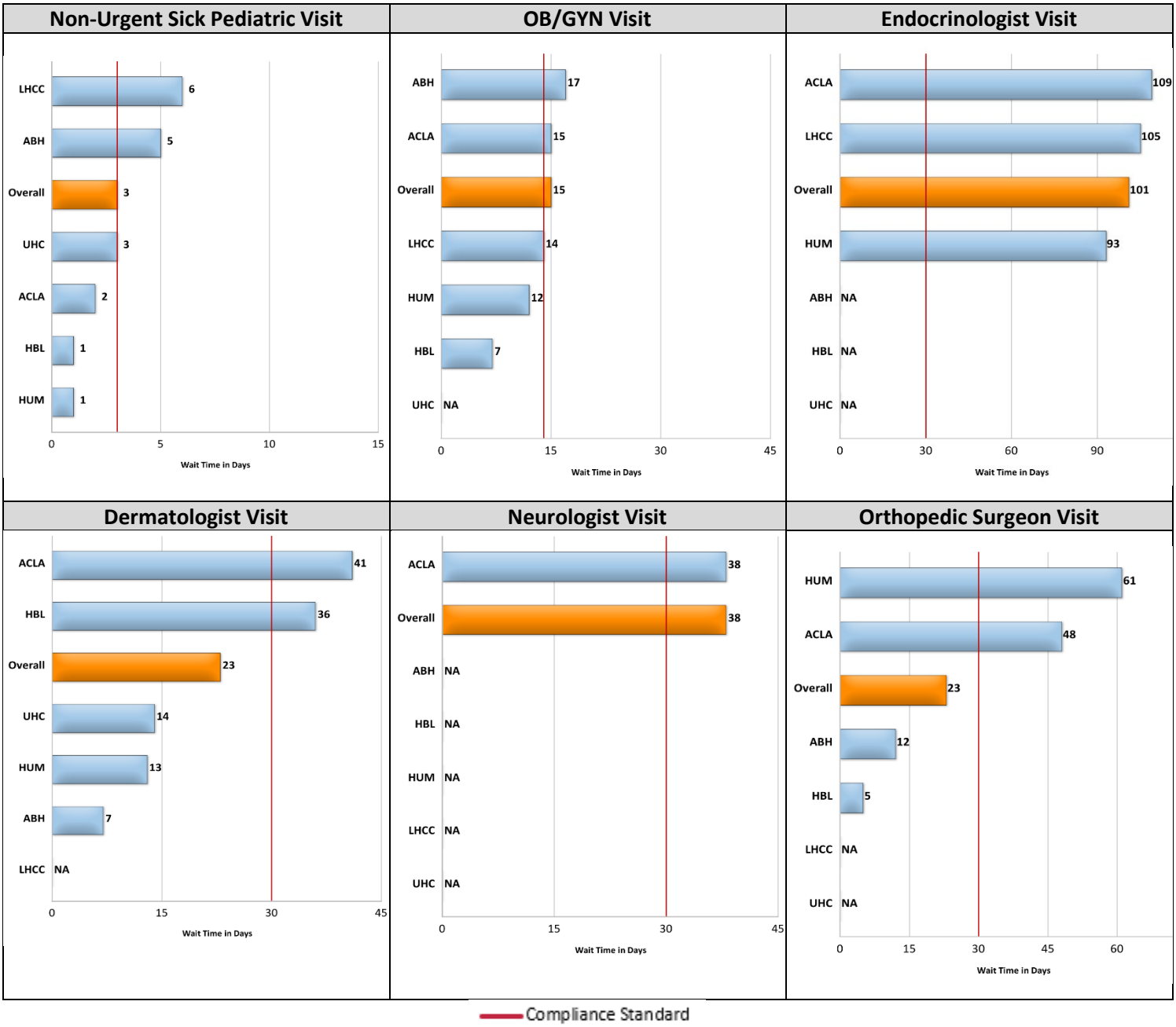


Wait Times

Figure 5-15 displays the average wait times for new patient appointments.

Figure 5-15—Provider Access Survey Average New Patient Wait Times

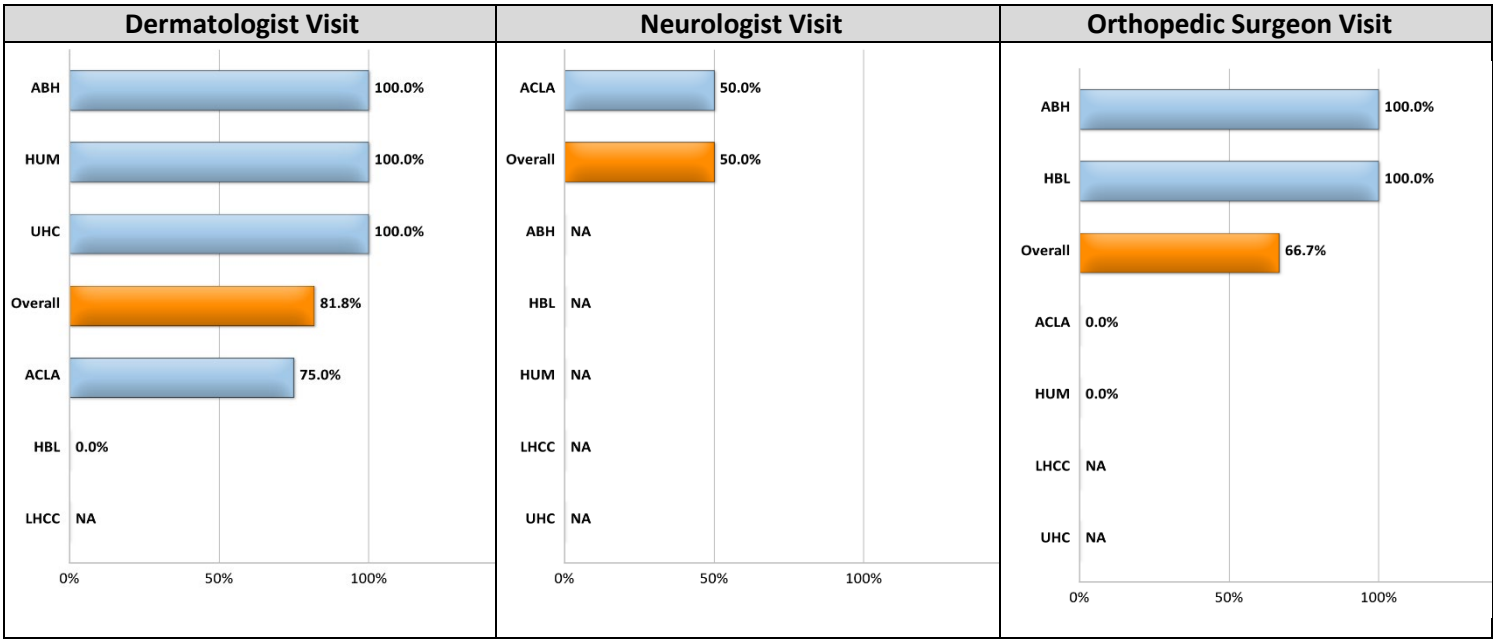




NA indicates that cases responding to the survey did not offer a new patient appointment date.

Figure 5-16 displays the percentage of cases within the appointment availability compliance standards for new patient appointments of six weeks (i.e., 30 business days) for routine primary care appointments, 72 hours (i.e., three business days) for non-urgent sick primary care appointments, one month (i.e., 30 calendar days) for specialist appointments, and 14 calendar days for initial prenatal care appointments (i.e., OB/GYN).

Figure 5-16—Appointments Meeting Compliance Standards



The denominator includes cases reached, accepting new patients, and offering an appointment for the given scenario.
NA indicates that cases responding to the survey did not offer a new patient appointment date.

Compliance Scores

Table 5-4 and Table 5-5 present the provider access survey weighted compliance scores by specialty and MCO, respectively.

Table 5-4—Provider Access Survey Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**1,151**	**281**	**39.4%**
Primary Care	360	54	29.4%
Pediatrics	240	94	52.5%
OB/GYNs	120	33	42.8%
Endocrinologists	94	27	44.7%
Dermatologists	99	28	36.4%
Neurologists	120	15	37.2%
Orthopedic Surgeons	118	30	40.1%

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

Table 5-5—Provider Access Survey Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**1,151**	**281**	**39.4%**
ABH	**188**	**32**	**40.4%**
Primary Care	60	8	29.4%
Pediatrics	40	3	40.8%
OB/GYNs	20	8	55.0%
Endocrinologists	12	2	36.1%
Dermatologists	18	6	46.3%
Neurologists	20	2	56.7%
Orthopedic Surgeons	18	3	38.9%
ACLA	**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%
HBL	**194**	**47**	**37.6%**
Primary Care	60	4	20.6%
Pediatrics	40	16	51.7%
OB/GYNs	20	4	38.3%
Endocrinologists	14	4	45.2%
Dermatologists	20	7	43.3%
Neurologists	20	3	31.7%
Orthopedic Surgeons	20	9	55.0%
HUM	**186**	**73**	**45.7%**
Primary Care	60	21	39.4%
Pediatrics	40	28	71.7%

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
OB/GYNs	20	7	45.0%
Endocrinologists	11	3	42.4%
Dermatologists	15	6	44.4%
Neurologists	20	2	21.7%
Orthopedic Surgeons	20	6	40.0%
LHCC	**200**	**22**	**31.2%**
Primary Care	60	4	23.9%
Pediatrics	40	11	45.0%
OB/GYNs	20	3	33.3%
Endocrinologists	20	4	40.0%
Dermatologists	20	0	11.7%
Neurologists	20	0	38.3%
Orthopedic Surgeons	20	0	26.7%
UHC	**192**	**43**	**38.0%**
Primary Care	60	4	33.3%
Pediatrics	40	22	61.7%
OB/GYNs	20	2	30.0%
Endocrinologists	18	5	42.6%
Dermatologists	14	2	19.0%
Neurologists	20	2	25.0%
Orthopedic Surgeons	20	6	35.0%

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

Table 5-6 presents the reasons for noncompliance.

Table 5-6—Provider Access Survey Reasons for Noncompliance

Reasons	ABH	ACLA	HBL	HUM	LHCC	UHC	Total
Noncompliant providers	**83.0% (156)**	**66.5% (127)**	**75.8% (147)**	**60.8% (113)**	**89.0% (178)**	**77.6% (149)**	**75.6% (870)**
Total reasons for noncompliance[1]	**158**	**129**	**147**	**114**	**178**	**149**	**875**
Provider does not participate with MCO or Louisiana Medicaid	8.5% (16)	9.9% (19)	8.8% (17)	18.3% (34)	6.0% (12)	14.1% (27)	10.9% (125)
Provider is not at site	10.1% (19)	4.7% (9)	2.6% (5)	2.7% (5)	5.5% (11)	4.2% (8)	5.0% (57)
Provider not accepting new patients	2.7% (5)	4.7% (9)	4.6% (9)	5.4% (10)	1.0% (2)	1.6% (3)	3.3% (38)
Wrong telephone number	1.1% (2)	3.1% (6)	6.2% (12)	0.5% (1)	5.0% (10)	4.7% (9)	3.5% (40)
No response/busy signal/ disconnected telephone number (after 2 calls)	21.3% (40)	24.1% (46)	28.4% (55)	18.3% (34)	32.5% (65)	24.5% (47)	24.9% (287)
Incorrect address reported	8.5% (16)	8.9% (17)	10.3% (20)	11.8% (22)	17.5% (35)	10.4% (20)	11.3% (130)
Address (suite number) needs to be updated	1.1% (2)	1.0% (2)	0.0% (0)	0.5% (1)	0.5% (1)	0.5% (1)	0.6% (7)
Wrong specialty reported	30.9% (58)	11.0% (21)	14.9% (29)	3.8% (7)	21.0% (42)	17.7% (34)	16.6% (191)

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.

After-Hours Telephone Survey Findings

Table 5-7 and Table 5-8 present the provider access survey after-hours weighted compliance scores by specialty and MCO, respectively.

Table 5-7—Provider Access Survey After-Hours Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**281**	**86**	**33.8%**
Primary Care	90	26	30.7%
Pediatrics	60	24	42.2%
OB/GYNs	30	11	41.1%

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Endocrinologists	20	6	35.0%
Dermatologists	22	4	21.2%
Neurologists	30	9	34.4%
Orthopedic Surgeons	29	6	26.4%

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

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

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**281**	**86**	**33.8%**
ABH	**45**	**6**	**15.6%**
Primary Care	15	3	22.2%
Pediatrics	10	1	10.0%
OB/GYNs	5	2	46.7%
Endocrinologists	2	0	16.7%
Dermatologists	4	0	0.0%
Neurologists	5	0	0.0%
Orthopedic Surgeons	4	0	0.0%
ACLA	**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%
HBL	**48**	**15**	**34.7%**
Primary Care	15	5	37.8%
Pediatrics	10	2	23.3%
OB/GYNs	5	4	80.0%

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Endocrinologists	3	1	44.4%
Dermatologists	5	1	20.0%
Neurologists	5	1	26.7%
Orthopedic Surgeons	5	1	20.0%
HUM	**45**	**25**	**58.5%**
Primary Care	15	12	80.0%
Pediatrics	10	8	83.3%
OB/GYNs	5	1	26.7%
Endocrinologists	2	1	50.0%
Dermatologists	3	0	11.1%
Neurologists	5	0	6.7%
Orthopedic Surgeons	5	3	60.0%
LHCC	**50**	**9**	**21.3%**
Primary Care	15	3	20.0%
Pediatrics	10	3	30.0%
OB/GYNs	5	1	20.0%
Endocrinologists	5	0	6.7%
Dermatologists	5	1	20.0%
Neurologists	5	0	13.3%
Orthopedic Surgeons	5	1	33.3%
UHC	**47**	**17**	**39.0%**
Primary Care	15	2	17.8%
Pediatrics	10	5	53.3%
OB/GYNs	5	1	26.7%
Endocrinologists	4	3	75.0%
Dermatologists	3	2	66.7%
Neurologists	5	4	80.0%
Orthopedic Surgeons	5	0	0.0%

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

Table 5-9 presents the after-hours noncompliance reasons.

Table 5-9—Provider Access Survey After-Hours Noncompliance Reasons

Reason for Noncompliance	Count	Rate[1] (%)
Voicemail or answering service	87	31.0%
Disconnected number	28	10.0%
Provider is not at site	28	10.0%
Incorrect address	27	9.6%
Continuous ringing	17	6.0%
Extended hold time	4	1.4%
Fax machine	2	0.7%
Busy signal	1	0.4%
Not a medical practice	1	0.4%
Total	**195**	**69.4%**

[1] The denominator includes all sampled providers.

NAV Audit

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

HSAG conducted the SFY 2024 validation of network adequacy indicators in accordance with the CMS EQR Protocol 4 activities, confirming the MCOs' 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 MCOs and LDH's network adequacy monitoring efforts.

Based on the results of a completed Information Systems Capabilities Assessment (ISCA) combined with a virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCOs' interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCO according to Table 5-10.

Table 5-10—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*

No identified indicators in scope of review obtained a *No Confidence* or *Low Confidence* rating determination for any MCO.

HSAG assessed the MCOs' provider-to-member ratios and determined that all MCOs met or exceeded LDH-established thresholds across all provider types.

HSAG assessed the MCOs' submitted distance results and found commonality among the MCOs that met the 100 percent threshold for distance requirements by provider type and urbanicity. Table 5-11 identifies the provider types/urbanicity for which all MCOs met the required LDH threshold for distance.

Table 5-11—Provider Types by Urbanicity, Compliant With Distance Standards Across All MCOs

Provider Type	Urbanicity
Adult PCP (Family/General Practice; Internal Medicine and Physician Extenders*)	Rural
Pharmacy	Rural

* 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 the appointment timeliness standards and determined that for the three behavioral health standards reported to LDH through the 359 template, all MCOs met the required compliance rate for non-urgent routine behavioral health care. ABH, ACLA, and LHCC met all three timeliness standards. Table 5-12 displays the behavioral health access and timeliness standard by visit type, which were met by each MCO.

Table 5-12—MCOs That Met Behavioral Health Provider Access and Timeliness Goals, by Standard

Type of Visit	Access/Timeliness Standard	Plans That Met Compliance Goal
Emergency Care	24 hours, 7 days/week within 1 hour of request	ABH, ACLA, HBL, LHCC, UHC
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	ABH, ACLA, LHCC
Non-Urgent Routine Behavioral Health Care	14 calendar days	ABH, ACLA, HBL, HUM, LHCC, UHC

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—MCO 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
American Society of Addiction Medicine (ASAM) Levels 3.3, 3.5, and 3.7	10 business days
Residential Withdrawal Management (WM)	24 hours when medically necessary
Psychiatric Residential Treatment Facilities (PRTF)	20 calendar days

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identify ways to improve the accessibility and timeliness of care for members. **[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, 93.5 percent of routine primary care cases and 92.9 percent of routine pediatric cases offered an appointment within the compliance standard. **[Timeliness and Access]**

- Overall, the MCOs had well-defined processes and procedures in place to ensure the efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- Acceptance of the MCO was inaccurate with 64.8 percent of providers in the PDV and 50.0 percent of locations in the provider access survey accepting the requested MCO. **[Quality and Access]**
- Overall, only 72.6 percent of providers in the PDV and 60.7 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 73.8 percent of providers in the PDV and 41.1 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 81.0 percent of PDV locations and 34.2 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Overall, only 17.9 percent of the provider access survey locations offered an appointment. Of the cases that offered an appointment, 81.8 percent of dermatology cases, 69.6 percent of non-urgent sick pediatric cases, 66.7 percent of non-urgent sick primary care cases, 66.7 percent of orthopedic surgeon cases, 53.3 percent of OB/GYN cases, 50.0 percent of neurology cases, and none of the endocrinology cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by MCO and survey type with an overall compliance score of 44.2 percent for the PDV, 39.4 percent for the provider access survey, and 33.8 percent for the after-hours provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with behavioral health having the lowest compliance score at 31.2 percent and pediatrics having the highest compliance score at 59.1 percent for the PDV. For the provider access survey, primary care exhibited the lowest compliance score at 29.4 percent and pediatrics exhibited the highest compliance score at 52.5 percent. While dermatologists exhibited the lowest compliance score at 21.2 percent, pediatrics exhibited the highest compliance score at 42.2 percent for the after-hours provider access survey. **[Quality and Access]**
- LDH provides multiple reporting templates for plan reporting on LDH-defined network adequacy standards including distance, provider-to-member ratios, and access and availability. HSAG has noted that there is a misalignment among these reporting templates and the contractual language for the standards. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following recommendations were identified:

- Acceptance of Louisiana Medicaid was inaccurate with 62.1 percent of providers in the PDV and 45.7 percent of locations in the provider access survey accepting Louisiana Medicaid. **[Quality and Access]**
- LDH should provide each MCO with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which each MCO 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, each MCO 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]**
- The MCOs 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]**
- HSAG recommends LDH review its reporting templates against the contractual language to align with and more accurately reflect the LDH-desired population stratifications by urbanicity and adult and pediatric populations to ensure consistent reporting by the MCEs. **[Quality, 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 percent.

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

Aggregate Results

Table 6-1 presents the 2022, 2023, and 2024 (review period) adult achievement scores for the Healthy Louisiana SWA.[6-1]

Table 6-1—Adult Achievement Scores for the Healthy Louisiana SWA

Measure	2022	2023	2024
Rating of Health Plan	80.18%	80.38%	77.66%
Rating of All Health Care	77.01%	76.24%	79.68% ↑
Rating of Personal Doctor	84.54%	85.60%	86.61% ↑
Rating of Specialist Seen Most Often	81.33%	82.46%	85.65%
Getting Needed Care	79.82%	80.47%	83.35%
Getting Care Quickly	83.25%	82.54%	82.56%
How Well Doctors Communicate	91.54%	93.11%	94.59% ↑
Customer Service	91.92%	92.14%	90.22%

↑ *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 the 2022, 2023, and 2024 (review period) general child achievement scores for the Healthy Louisiana SWA.

Table 6-2—General Child Achievement Scores for the Healthy Louisiana SWA

Measure	2022	2023	2024
Rating of Health Plan	88.13%	86.74%	88.48% ↑
Rating of All Health Care	87.67%	89.15%	89.95% ↑
Rating of Personal Doctor	90.35%	90.72%	91.73%
Rating of Specialist Seen Most Often	84.31%	85.95%	87.54%
Getting Needed Care	85.25%	89.06%	84.66%
Getting Care Quickly	87.85%	89.34%	89.88% ↑
How Well Doctors Communicate	93.70%	95.46%	94.06%

[6-1] HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, caution should be exercised when comparing the 2022 and 2023 rates to 2024, as the 2022 and 2023 rates include five MCOs and the 2024 rate includes six MCOs.

Measure	2022	2023	2024
Customer Service	87.92%	88.47%	88.09%

↑ *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.*

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the adult population, the 2024 Healthy Louisiana SWA's scores were statistically significantly higher than the 2024 NCQA national averages for *Rating of All Health Care*, *Rating of Personal Doctor,* and *How Well Doctors Communicate*. **[Quality]**
- For the general child population, the 2024 Healthy Louisiana SWA's scores were statistically significantly higher than the 2024 NCQA national averages for *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly*. **[Quality and Timeliness]**

For the MCOs statewide, the following opportunities for improvement were identified:

- For the adult and general child populations, the 2024 Healthy Louisiana SWA'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 the MCOs statewide, the following recommendations were identified:

- HSAG recommends that the MCOs monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**

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.[6-2] 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."

[6-2] 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.[6-3]

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.[6-4] 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 (↑).[6-5] Conversely, an MCO

6-3 National data were obtained from NCQA's 2024 Quality Compass.

6-4 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.

6-5 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 2023 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

Aggregate Results

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

Table 7-1—Adult Statewide Results for the Healthy Louisiana SWA

Measure	2023	2024
Rating of Health Plan	58.96%	56.43%
How Well People Communicate	90.06%	92.65%
Cultural Competency	73.77%+	82.85%+
Helped by Counseling or Treatment	67.65%	69.38%
Treatment or Counseling Convenience	86.70%	88.46%
Getting Needed Treatment	77.08%	81.83%
Help Finding Counseling or Treatment	47.04%	52.90%
Customer Service	67.14%+	71.32%
Helped by Crisis Response Services	76.09%	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 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 the Healthy Louisiana SWA.

Table 7-2—Child Statewide Results for the Healthy Louisiana SWA

Measure	2023	2024
Rating of Health Plan	62.67%	65.18%
How Well People Communicate	92.54%	90.74%
Cultural Competency	97.85%+	90.17%+
Helped by Counseling or Treatment	58.20%	56.92%
Treatment or Counseling Convenience	89.52%	86.12%
Getting Needed Treatment	77.36%	77.13%

[7-1] HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, caution should be exercised when comparing the 2022 and 2023 rates to 2024, as the 2022 and 2023 rates include five MCOs and the 2024 rate includes six MCOs.

Measure	2023	2024
Help Finding Counseling or Treatment	41.85%+	46.93%+
Customer Service	61.54%+	59.54%+
Getting Professional Help	88.83%	85.72%
Help to Manage Condition	85.94%	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 2023 score.*

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

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the adult and child populations, the 2024 Healthy Louisiana SWA scores were not statistically significantly higher in 2024 than 2023 on any of the measures; therefore, no strengths were identified.

For the MCOs statewide, the following opportunities for improvement were identified:

- For the adult and child populations, the 2024 Healthy Louisiana SWA scores were not statistically significantly lower in 2024 than 2023 on any of the measures; therefore, no opportunities for improvement were identified.

For the MCOs statewide, the following recommendations were identified:

- HSAG recommends that the MCOs monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**

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 (i.e., Health Louisiana SWA) 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 (↓) 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

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Health equity is achieved when everyone has the opportunity to attain their full health potential, and no one is disadvantaged because of socially determined circumstances. Achieving it requires focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.[8-1] In an effort to measure and address health disparities, LDH and HSAG partnered to perform the 2023 Annual Health Disparities Focus Study.

In order to understand health disparities identified for the Louisiana Medicaid population, it is important to consider the demographic breakdowns of this population. In 2022, Louisiana's Medicaid population consisted of the following groups: Black or African American (48.6 percent), White (38.2 percent), Hispanic/Latino (6.1 percent), More than One Race (5.5 percent), Asian/Native Hawaiian and Pacific Islander (1.3 percent), and American Indian or Alaska Native (0.4 percent).[8-2] About 64 percent of children living in small towns or rural areas belong to Louisiana's Medicaid population compared to 54 percent of children living in urban areas. Similarly, non-elderly adults constitute a larger percentage of Louisiana's Medicaid rural population (32 percent) compared to non-elderly adults living in urban areas (24 percent).[8-3]

For the 2023 Annual Health Disparities Focus Study, HSAG used MCO-provided CY 2022 stratified HEDIS and non-HEDIS indicator rates to identify disparities based on race, ethnicity, and geography, where applicable. HSAG also used the MCO-provided CAHPS data files to identify disparities based on race and ethnicity. A disparity was identified if the relative difference in an indicator rate between the group of interest (e.g., Black or African American group for the race demographic stratification) and the reference group (e.g., the White group for the race demographic stratification) was greater than 10 percent. Please refer to the Methodology section below for more information.

High-Level Findings

Table 8-1 displays the percentage and count of indicators (out of 41 possible indicators) for which disparities were identified or were not identified at the statewide level for each demographic

[8-1] Healthy People 2030. Health Equity in Healthy People 2030. Available at: https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030. Accessed on: Jan 6, 2025.

[8-2] Kaiser Family Foundation. Distribution of People Ages 0-64 with Medicaid by Race/Ethnicity. 2023. Available at: https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on: Jan 6, 2025.

[8-3] Osorio A, Alker J, Park E. Medicaid's Coverage Role in Small Towns and Rural Areas: Aug 17, 2023. Available at: https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/. Accessed on: Jan 6, 2025.

stratification. Please note, for the geography stratification, only 15 indicators were assessed for disparities. Additionally, for each demographic stratification, the sum of the count of indicators that are better than, worse than, or similar to (i.e., no disparity identified) the reference group may not equal the total number of possible indicators due to suppressed rates (i.e., small numerators or denominators).

Table 8-1—Overall Statewide Disparities by Demographic Stratification

Demographic Stratification	Better Than the Reference Group	No Disparity Identified	Worse Than the Reference Group
Race (n=41)			
White	—	—	—
American Indian or Alaska Native	6 (37.5%)	7 (43.8%)	3 (18.8%)
Asian	4 (17.4%)	15 (65.2%)	4 (17.4%)
Black or African American	5 (12.2%)	29 (70.7%)	7 (17.1%)
Native Hawaiian or Other Pacific Islander	1 (100.0%)	0 (0.0%)	0 (0.0%)
Other	8 (25.0%)	22 (68.8%)	2 (6.3%)
Unknown	6 (15.8%)	21 (55.3%)	11 (28.9%)
Ethnicity (n=41)			
Non-Hispanic/Latino	—	—	—
Hispanic/Latino	17 (43.6%)	18 (46.2%)	4 (10.3%)
Unknown	6 (14.6%)	21 (51.2%)	14 (34.1%)
Geography (n=15)			
Urban	—	—	—
Rural	0 (0.0%)	10 (66.7%)	5 (33.3%)
Unknown	0 (0.0%)	3 (23.1%)	10 (76.9%)

—indicates the reference group for the select demographic stratification.

The following statewide disparities were found based on race, ethnicity, and geography:

- For the American Indian or Alaska Native group:
  - Rates were suppressed at the statewide level for 25 of 41 indicators, including all 20 indicators based on CAHPS data.
  - Three of the six indicators where the rate for American Indian or Alaska Native group was better than the rate for the White group were in the Women's Health domain.
  - Two of the three indicators where the rate for the American Indian or Alaska Native group was worse than the rate for the White group were in the Children's Health domain.
- For the Asian group:
  - Rates were suppressed at the statewide level for 18 of 41 indicators, including 17 of the 20 indicators based on CAHPS data.

  - Two of the four indicators where the rate for the Asian group was better than the rate for the White group were in the Children's Health domain.
  - Two of the four indicators where the rate for the Asian group was worse than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization. The other two indicators were in the Behavioral Health domain.
- For the Black or African American group:
  - Three of the five indicators where the rate for the Black or African American group was better than the rate for the White group were in the Women's Health domain.
  - The rates for the Black or African American group were worse than the rates for the White group for a majority of indicators in the Behavioral Health domain.
- For the Native Hawaiian or Other Pacific Islander group:
  - Rates were suppressed at the statewide level for 40 of 41 indicators.
  - The one reportable rate for the Native Hawaiian or Other Pacific Islander group was better than the rate for the White group (*Child and Adolescent Well-Care Visits* [WCV]).
- For the Other group:
  - Four of the eight indicators where the rate for the Other group was better than the rate for the White group were in the Children's Health domain.
  - The two indicators where the rate for the Other group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain.
- For the Unknown race group:
  - Two of the six indicators where the rate for the Unknown race group was better than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization.
  - Six of the 11 indicators where the rate for the Unknown race group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain. Additionally, the rates for the Unknown race group were below the rates for the White race group for all three indicators in the Behavioral Health domain.
- For the Hispanic/Latino group:
  - The rates for the Hispanic/Latino group were better than the rates for the Non-Hispanic/Latino group for 17 of 39 indicators with reportable rates, including all six indicators in the Children's Health domain and four of seven indicators in the Women's Health domain.
  - Two of the four indicators where the rate for the Hispanic/Latino group was worse than the Non-Hispanic/Latino group were in the Chronic Conditions domain, specifically related to HbA1c control for diabetes.
- For the Unknown ethnicity group:
  - Four of the six indicators where the rate for the Unknown ethnicity group was worse than the rate for the Non-Hispanic/Latino group were in the Member Experience With Health Plan and Providers domain.

  - The rates for the Unknown ethnicity group were worse than the rates for the Non-Hispanic/Latino group for a majority of measures in the Women's Health and Behavioral Health domains.
- For the Rural group:
  - No rates for the Rural group were better than the rates for the Urban group.
  - Four of the five indicators where the rate for the Rural group was worse than the rate for the Urban group were in the Women's Health domain, specifically related to postpartum contraception utilization.
- For the Unknown geography group:
  - No rates for the Unknown geography group were better than the rates for the Urban group.
  - The rates for the Unknown geography group were worse than the rates for the Urban geography group for all five indicators in the Children's Health domain and two of the three indicators in the Women's Health domain.

For race, ethnicity, and geography, the Unknown group had the largest number of disparities identified where the rate was worse than the rate for the reference group. HSAG recommends LDH and the MCOs work to improve data collection for race, ethnicity, and geography of their members to improve the ability to identify disparities and ultimately address these disparities. For the Hispanic/Latino group, rates were better than the rates for the Non-Hispanic/Latino group for a majority of indicators within the Children's Health domain and Women's Health domain, and for almost one-third of the indicators within the Member Experience With Health Plan and Providers domain. However, given the volume of members with Unknown ethnicity information, more information is necessary to assess if these disparities still persist once ethnicity information is better classified. Additionally, HSAG recommends LDH consider collecting race, ethnicity, and geography information at a member-level so relationships across demographic categories can be better understood. The Black or African American group had low performance related to low birthweight births, well-child visits for children under 15 months of age, and a follow-up care after ED visits or hospitalizations related to behavioral health. These disparities align with disparities seen nationally, so HSAG recommends LDH and the MCOs focus improvement efforts in alignment with national initiatives to close these gaps in care.

Methodology

Objectives

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 CY 2022 data.

Technical Methods of Data Collection

HSAG used the MCO-provided *Race Ethnicity and Rural Urban Stratification* Microsoft Excel (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 8-2 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 8-2—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)		
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

Measure Indicator	Data Source	Stratification
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)*		
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 8-2. 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 8-2 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 8-3 provides an example of how the transformed rates were calculated.

Table 8-3—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 8-2, HSAG identified statewide and MCO-specific disparities based on race, ethnicity, and geography, where applicable (see Table 8-2 for which stratifications apply to each measure indicator). Table 8-4 and Table 8-5 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 8-4 and Table 8-5; however, the race and ethnicity categories listed were used in the analysis, where applicable.

Table 8-4—Race Categories

Race Category	Groups Included
White*	White
Black or African American	Black or African American, Black or African-American

Race Category	Groups Included
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 8-5—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 8-6 displays the geography categories and the parishes included in each.

Table 8-6—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,[8-4] 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.

[8-4] Please refer to those measure indicators in Table 8-2 marked with an asterisk (*) for measure indicators for which a lower rate indicates better performance.

How Conclusions Were Drawn

To draw conclusions about identified statewide health disparities, HSAG assessed whether specific measure indicators, domains, or demographic groups had disparities consistently identified.

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 each 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").

The MCOs included in the CMPE reviews are displayed in Table 9-1.

Table 9-1—Plan Names

MCO Name	Acronym or Abbreviated Reference
Aetna Better Health	ABH
AmeriHealth Caritas Louisiana	ACLA
Healthy Blue	HBL
Humana Healthy Horizons	HUM
Louisiana Healthcare Connections	LHCC
UnitedHealthcare Community	UHC

[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: Jan 7, 2025.

The results of both reviews, including conclusions, strengths, and opportunities for improvement, are included in this EQR technical report.

Aggregate Results

During the CY 2023 (review period) review, a total of 588 case files were reviewed. Table 9-2 summarizes the aggregate and stratified scores for each performance domain.

Table 9-2—Performance Scores by Domain*

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
Assessment (Aggregate)	**842**	**122**	**198**	**602**	**83%**
ABH	159	50	28	63	88%
ACLA	108	2	14	176	89%
HBL	130	20	34	116	82%
HUM	219	16	33	32	88%
LHCC	128	29	39	104	80%
UHC	98	5	50	111	67%
Care Planning (Aggregate)	**2,063**	**131**	**496**	**1,426**	**82%**
ABH	384	51	72	193	86%
ACLA	206	1	111	382	65%
HBL	443	29	32	196	94%
HUM	423	8	43	226	91%
LHCC	367	35	96	202	81%
UHC	240	7	142	227	63%
Enrollee Interaction and Coordination of Services (Aggregate)	**843**	**91**	**242**	**0**	**79%**
ABH	118	18	64	0	68%
ACLA	182	8	10	0	95%
HBL	143	31	26	0	87%
HUM	177	10	13	0	94%
LHCC	118	11	71	0	65%

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
UHC	105	13	58	0	67%

* The results reflected in this table are not statistically significant or representative of performance as related to the MCO's membership as a whole.
** "Percentage Met" is the percentage of *Met* and *Met Based on Due Diligence* elements excluding any *NA* cases.

During the CY 2024 review, a total of 129 case files were reviewed. Table 9-3 summarizes the aggregate and stratified scores for each performance domain.

Table 9-3—Performance Scores by Domain*

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
Assessment (Aggregate)	**105**	**69**	**58**	**155**	**75%**
ABH	5	6	9	28	55%
ACLA	20	15	18	37	66%
HBL	13	8	14	19	60%
HUM	6	8	0	1	100%
LHCC	35	17	2	36	96%
UHC	26	15	15	34	73%
Care Planning (Aggregate)	**702**	**58**	**360**	**299**	**68%**
ABH	82	1	47	46	64%
ACLA	141	9	109	71	58%
HBL	98	4	61	35	63%
HUM	27	3	14	11	68%
LHCC	199	30	29	72	89%
UHC	155	11	100	64	62%
Enrollee Interaction and Coordination of Services (Aggregate)	**131**	**37**	**90**	**0**	**65%**
ABH	15	3	14	0	56%
ACLA	32	10	18	0	70%
HBL	16	7	13	0	64%
HUM	6	3	1	0	90%

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
LHCC	32	5	23	0	62%
UHC	30	9	21	0	65%

* The results reflected in this table are not statistically significant or representative of performance as related to the MCO's membership as a whole.
** "Percentage Met" is the percentage of *Met* and *Met Based on Due Diligence* elements excluding any *NA* cases.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, 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 the six MCOs demonstrated overall performance of greater than 80 percent for all three domains. **[Quality]**
- The results of both reviews demonstrated that five of the six MCOs were successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans, and MCT development. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- While the MCOs achieved successes with initial enrollee engagement case activities, all six MCOs demonstrated opportunity for improvement with elements related to ongoing scheduled case management activities. **[Timeliness]**
- The MCOs reported varying levels of success with enrollee engagement; however, the MCOs were generally unable to demonstrate use of alternative options for engagement. HSAG observed limited documentation of attempts to contact enrollees' formal or informal supports (i.e., physicians, BH professionals, pharmacists, personal assistants/homemakers) to assist with engagement attempts. In addition, while all six MCOs had UTR processes to assist with enrollee engagement, the MCOs were unable to demonstrate consistent application of those processes. **[Quality and Timeliness]**
- For the CY 2024 review, although the MCOs were generally successful in developing a POC with enrollees, there was opportunity for improvement related to person-centered planning. **[Quality]**

For the MCOs statewide, the following recommendations were identified:

- The MCOs should evaluate their 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,

POC updates, enrollee contacts) should be considered; leadership audits may need to focus on these time-sensitive elements. **[Quality and Timeliness]**

- The MCOs should consider efforts to strengthen documentation of an enrollee's refusal of in-person contact for completion of reassessments, plan of care updates, and scheduled contacts. The MCOs may consider reeducation of case managers on documentation expectations. **[Quality and Timeliness]**
- The MCOs must evaluate their processes to ensure enrollee engagement if the enrollee refuses face-to-face contact. The MCOs should consider revisions to processes to, at a minimum, offer telephonic contact for those enrollees refusing face-to-face contact, and should consider virtual face-to-face options and in-person visits with enrollees at the location of their choice. All case management staff members should be trained on the expectation to complete case management activities in alternate formats if an enrollee refuses face-to-face contact. **[Quality and Timeliness]**
- The MCOs should evaluate MCT processes to ensure MCT meetings are conducted at regular intervals, or that an enrollee's refusal of MCT meetings is documented. The MCOs should consider efforts to educate enrollees on the importance of the MCT. The MCOs could consider evaluating documentation templates to identify opportunities to reduce duplication of case manager efforts. **[Timeliness]**
- The MCOs should reeducate case managers on expectations for person-centered planning and inclusion of all required POC elements. **[Quality]**

Methodology

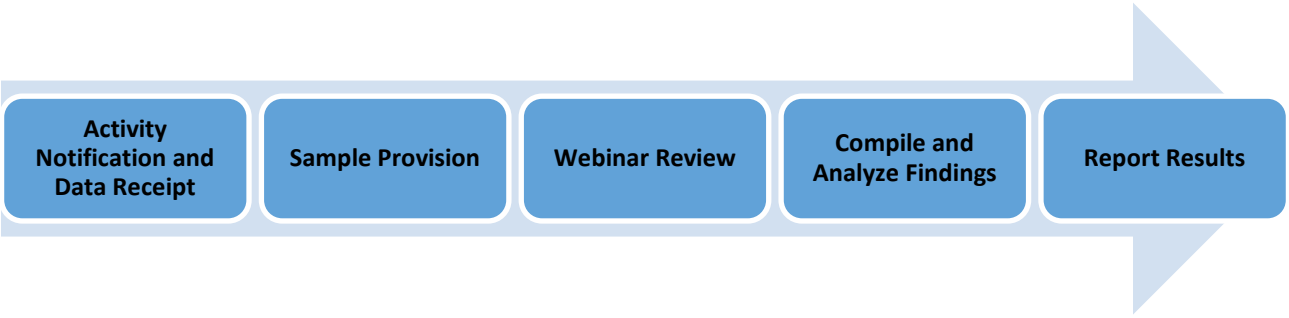
Objectives

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 CMPE 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 9-4—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 9-5—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 9-6—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. HSAG also developed an aggregate report of all findings, stratified by MCO, which was delivered to LDH.

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 9-7, which demonstrated each MCO's compliance with contractual requirements.

Table 9-7—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.		✓	
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. (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 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 an 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.	✓		✓

Aggregate Results

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

Table 10-1—2024 (CY 2023) QRS Results

Composites and Subcomposites	ABH	ACLA	HBL	LHCC	UHC
Overall Rating*	**3.5**	**3.5**	**3.5**	**3.5**	**3.5**
Consumer Satisfaction	**3.5**	**3.5**	**4.0**	**4.0**	**5.0**
Getting Care	4.5	2.5	3.5	3.5	Insufficient Data
Satisfaction with Plan Physicians	3.5	3.5	4.5	5.0	5.0
Satisfaction with Plan Services	2.5	3.5	4.5	4.0	5.0
Prevention and Equity	**2.5**	**3.0**	**3.0**	**2.5**	**3.0**
Children and Adolescent Well-Care	2.0	2.5	2.5	2.0	2.5
Women's Reproductive Health	2.5	2.0	3.0	2.5	3.5
Cancer Screening	2.0	3.0	2.0	3.0	3.0
Equity	5.0	5.0	5.0	NC	5.0
Other Preventive Services	3.5	4.0	4.0	3.5	3.0
Treatment	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
Respiratory	3.5	3.0	3.5	3.0	1.5
Diabetes	3.5	3.5	4.0	4.0	4.5
Heart Disease	3.5	3.0	2.5	3.5	3.0
Behavioral Health—Care Coordination	1.5	1.0	1.5	1.0	1.5
Behavioral Health—Medication Adherence	3.5	2.5	2.5	3.5	2.0
Behavioral Health—Access, Monitoring, and Safety	4.0	3.5	4.0	3.0	4.0
Risk-Adjusted Utilization	3.0	3.0	3.0	3.0	3.0
Reduce Low Value Care	2.0	2.0	2.0	2.0	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.*
Insufficient Data indicates that the plan was missing most data for the composite or subcomposite.
NC indicates that the plan received a rating of 0 for the measure in this composite.
Note: A sixth MCO, HUM, was not included in the analysis as the MCO did not start providing coverage until MY 2023.

For the Overall Rating, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.5 stars. For the Consumer Satisfaction composite, one MCO (UHC) received 5.0 stars, two MCOs (HBL and LHCC) received 4.0 stars, and two MCOs (ABH and ACLA) received 3.5 stars. For the Prevention and Equity composite, ACLA, HBL, and UHC each received 3.0 stars, while the remaining two MCOs (ABH and LHCC) both received 2.5 stars. For the Treatment composite, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.0 stars.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the Consumer Satisfaction composite, one of five MCOs (UHC) received 5.0 points and two of five MCOs (HBL and LHCC) received 4.0 points, demonstrating that most MCO members are satisfied with their health plan, providers, and the care they receive. Of note, despite UHC not having sufficient data for the Getting Care subcomposite, UHC received 5.0 points for the two remaining subcomposites (Satisfaction with Plan Physicians and Satisfaction with Plan Services), demonstrating strength for this MCO. **[Quality and Timeliness]**
- For the Prevention and Equity composite, four MCOs (ABH, ACLA, HBL, and UHC) received 5.0 points for the Equity subcomposite, demonstrating strength for health plans collecting race and ethnicity information from their members. Additionally, four MCOs (ABH, ACLA, HBL, and LHCC) received at least 3.5 points for the Other Preventive Services subcomposite, demonstrating strength for these MCOs related to providing chlamydia screenings in women and tobacco cessation counseling. **[Quality and Access]**
- For the Treatment composite, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received at least 3.5 points for the Diabetes subcomposite, demonstrating strength for these MCOs related to diabetic care. Additionally, four MCOs (ABH, ACLA, HBL, and UHC) received at least 3.5 points for the Behavioral Health—Access, Monitoring, and Safety subcomposite, demonstrating strengths for these MCOs in providing care for adults and children using antipsychotics, adults and children with SUD, and children using ADHD medication. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- For the Consumer Satisfaction composite, ABH and ACLA were the lowest performing MCOs. ABH received 2.5 points for the Satisfaction with Plan Services subcomposite, demonstrating opportunities for this MCO to ensure members are satisfied with their health plan. ACLA received 2.5 points for the Getting Care subcomposite, demonstrating opportunities for this MCO to ensure members get the care they need. **[Quality and Timeliness]**
- For the Prevention and Equity composite, ABH and LHCC were the lowest performing MCOs with both MCOs receiving 2.5 points. None of the five MCOs received more than 2.5 points for the Children and Adolescent Well-Care subcomposite, demonstrating opportunities for improvement for

the MCOs related to ensuring children and adolescents receive important immunizations as well as ensuring BMI percentiles are documented for children and adolescents. **[Quality and Access]**

- For the Treatment composite, five MCOs scored the lowest on the Behavioral Health—Care Coordination subcomposite, with ACLA and LHCC receiving 1.0 point each and the remaining MCOs receiving 1.5 points each, demonstrating opportunities for improvement for the MCOs to ensure timely follow-up care after hospitalizations and ED visits for mental illness.
- Additionally, five MCOs demonstrated opportunities for improvement for the Reduce Low Value Care subcomposite, with each MCO receiving 2.0 points; these MCOs should ensure members with low back pain do not receive unnecessary imaging tests. **[Quality, Timeliness, and Access]**

The MCOs 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. HUM will be included in future Health Plan Report Cards.

[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 2023) 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: Jan 7, 2025.

- 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 Aggregate Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2024 to comprehensively assess the MCOs' performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides the MCOs' aggregate 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, Timeliness, and Access	• For the NAV audit, for provider-to-member ratios, all MCOs met or exceeded LDH-established thresholds across all provider types. • The MCOs demonstrated strength in compliance by successfully remediating all 14 elements, indicating that initiatives were implemented and demonstrated compliance with the requirements under review. • The MCOs demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identify ways to improve the accessibility and timeliness of care for members. • The MCOs demonstrated strength in three measures from the adult CAHPS survey. Overall, the Healthy Louisiana SWA's 2024 adult achievement scores were significantly higher than the 2024 NCQA adult Medicaid national averages for three measures: *Rating of All Health Care*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*.
Quality and Timeliness	• The MCOs demonstrated strength in three measures from the child CAHPS survey. The Healthy Louisiana SWA's 2024 general child achievement scores were significantly higher than the 2024 NCQA general child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly*.
Quality	• The MCOs developed and carried out a methodologically sound design for all five PIPs that facilitated valid and reliable measurement of objective indicator performance over time. • The MCOs carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. • The MCOs 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.

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

Overall MCO Opportunities for Improvement	
Quality and Access	• The PDV indicated that, overall, the provider information maintained and provided by the plans showed a low level of agreement between the MCOs' online provider directories and the information obtained during the telephone calls to the providers' offices.
Quality, Timeliness, and Access	• HSAG's provider access survey indicated that, overall, the provider information maintained and provided by the plans showed a low level of agreement between the MCOs' provider data and the information obtained during the telephone calls to the providers' offices. • The rates of all MCOs, as well as the SWA rate 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 the MCOs have 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. • The rates of all MCOs, as well as the SWA rate 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, the rates of all MCOs, as well as the SWA rate 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 the MCOs have room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. • LDH provides multiple reporting templates for plan reporting on LDH-defined network adequacy standards including distance, provider-to-member ratios, and access and availability. HSAG has noted that there is a misalignment among these reporting templates and the contractual language for the standards. • The 2024 Health Plan Report Card showed that, for the Overall Rating, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.5 stars.
Quality	• The rates of all MCOs, as well as the SWA rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with facilitating appropriate post-discharge planning and care coordination. • The rates of all MCOs, as well as the SWA rate on the *Use of Imaging Studies for Low Back Pain* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that providers properly order imaging studies. • The rates of all MCOs, as well as the SWA rate on the *Non-Recommended Cervical Screening in Adolescent Females* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that providers avoid unnecessary cervical cancer screenings for adolescent females.

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 the MCOs review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCOs 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
• 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 the MCOs 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 the MCOs.	Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention
• To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommends that the MCOs work with providers to improve post-discharge planning and care coordination.	Goal 2: Improve coordination and transitions of care
• To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that the MCOs focus their efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that the MCOs work with providers to trial solutions to reduce the inappropriate ordering of imaging studies.	Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention
• To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females.	Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
• HSAG recommends that LDH provide each MCO with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which each MCO 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
• In addition to updating provider information, HSAG recommends that each MCO 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 the MCOs 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
• HSAG recommends that LDH review its reporting templates against the contractual language to align with and more accurately reflect the LDH-desired population stratifications by urbanicity and adult and pediatric populations to ensure consistent reporting by the MCEs.	Goal 3: Facilitate patient-centered, whole-person 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. Each MCO's response is included in the SFY 2024 EQR technical report produced for each MCO. Please reference the MCO-specific reports to review MCO responses to prior EQR recommendations and HSAG's assessment of their responses.

Appendix A. MCO Health Equity Plan Summaries

For the annual EQR technical report, LDH asked HSAG to summarize information from each MCO's health equity plan submissions from July 2024. Each MCO's response is included in the SFY 2024 EQR technical report produced for each MCO. Please reference the MCO-specific reports to review MCO responses.