LOUISIANA DEPARTMENT OF HEALTH

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

External Quality Review Technical Report

Aggregate Report for the Prepaid Ambulatory Health Plans

February 2025

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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 healthcare 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 12, 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 12, 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, and interpretation of the network	Protocol 4. Validation of Network Adequacy	✓	✓	✓

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 12, 2024.

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

Report Purpose

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

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

Definitions

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

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

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

Methodologies

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

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 PAHP, as well as the program overall. To produce the PAHP 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 PAHPs:

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

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 PAHP.

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 members. LDH plans to incorporate goals from the National Quality Strategy in the quality strategy in

[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 12, 2024.

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

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

Actions on External Quality Review Recommendations

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

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

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

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

SFY 2022–2023 EQRO Recommendations	LDH Actions
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.	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

This annual EQR technical report includes aggregated results of all EQR-related activities for the two PAHPs that serve as Louisiana Medicaid's dental benefit program managers (DBPMs), DentaQuest USA Insurance Company (DentaQuest) (DQ) and Managed Care North America (MCNA), conducted with Louisiana Medicaid managed care throughout SFY 2024.

Validation of Performance Improvement Projects

In SFY 2024, LDH required the PAHPs to initiate new PIPs. Each PAHP initiated two new PIPs, the *Increase the Percentage of EPSDT [Early and Periodic Screening, Diagnostic and Treatment] Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Servic*e PIP and the *Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday* PIP. The PAHPs worked on the design and baseline data collection for the new PIPs in SFY 2024 and will submit the new PIPs for initial validation in January 2025.

Validation of Performance Measures

For SFY 2024, HSAG administered an Information Systems Capabilities Assessment (ISCA) to the PAHPs to assess their information systems (IS) and data processes. HSAG's review of the ISCA completed by the PAHPs found that both MCNA and DQ met the requirement of maintaining IS that collect, analyze, integrate, and report data that comply with LDH and federal reporting requirements. Additionally, both PAHPs' rates on the CMS-416 12b performance measure increased from the previous reporting period, indicating that the PAHPs have put forth effort to improve access to preventative dental services. However, both PAHPs' rates fell below the goal established by LDH for the CMS-416 12b performance measure, indicating opportunities for continued improvement on the measure.

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG reviewed the PAHPs' corrective action plans (CAPs) that the PAHPs prepared to remediate any deficiencies from the 2023 CR. HSAG and LDH evaluated the sufficiency of the CAPs. DQ achieved compliance in 109 of 109 elements from the 2023 CAPs. MCNA achieved compliance in one of one element from the 2023 CAPs. The PAHPs demonstrated that they successfully remediated 110 of 110 elements, indicating the necessary initiatives were implemented and demonstrated compliance with the requirements under review.

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

Validation of Network Adequacy

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

HSAG assessed the dental PAHPs and found commonality among both that fell below the thresholds for distance requirements by provider type and urbanicity. Table 1-4 displays the common parishes between both PAHPs that fell below the required threshold.

Table 1-4—Provider Types That Fell Below the Required Threshold Across Both Dental PAHPs, by Urbanicity

Provider Type	Urbanicity	Parishes Reported Non-Compliant for Both Dental PAHPs
Members in Urban Parishes Residing w/in 10 Miles of One Open Practice Main Dentist	Urban	Bossier; Calcasieu; DeSoto; Grant; Plaquemines; Saint Bernard; Saint Helena; Terrebone; Union
Members in Rural Parishes Residing w/in 30 Miles of One Open Practice Main Dentist	Rural	None
Members Residing w/in 60 Miles of One Endodontist (75%) or no more than 75 miles (100%)	Urban	Bossier; Caddo; Cameron; DeSoto; Lafayette
	Rural	Acadia; Beauregard; Bienville; Caldwell; Catahoula; Claiborne; East Carroll; Franklin; Jackson; Lincoln; Madison; Morehouse; Red River; Richland; Sabine; Tensas; Vermilion; West Carroll
Members Residing w/in 60 Miles of One Oral Surgeon (75%) or no more than 75 miles (100%)	Urban	Calcasieu; Cameron
	Rural	Beauregard
Members Residing w/in 60 Miles of One Orthodontist (75%) or no more than 75 miles (100%)	Urban	Grant
	Rural	Catahoula; Concordia; LaSalle; Natchitoches; Sabine; Vernon
Members Residing w/in 60 Miles of One Periodontist (75%) or no more than 75 miles (100%)	Urban	Bossier; Caddo; Calcasieu; Cameron; DeSoto; Grant; Ouachita; Rapides; Union
	Rural	Acadia; Allen; Avoyelles; Beauregard; Bienville; Caldwell; Catahoula; Concordia; Evangeline; Franklin; Jackson; Jefferson Davis; LaSalle; Lincoln; Madison; Morehouse; Natchitoches; Richland; Sabine; Saint Landry; Tensas; Vermilion; Vernon; West Carroll; Winn
Members Residing w/in 60 Miles of One Prosthodontist (75%) or no more than 75 miles (100%)	Urban	Bossier; Caddo; Calcasieu; Cameron; DeSoto; Grant; Ouachita; Rapides; Union
	Rural	Allen; Avoyelles; Beauregard; Bienville; Caldwell; Catahoula; Claiborne; Concordia; East Carroll; Evangeline; Franklin; Jackson; LaSalle; Lincoln; Madison; Morehouse; Natchitoches; Red River; Richland; Sabine; Vernon; Webster; West Carroll; Winn

2. Validation of Performance Improvement Projects

Aggregate Results

During SFY 2024 (review period), LDH required the PAHPs to initiate two new PIPs. The PAHPs worked on the design and baseline data collection for the new PIPs in SFY 2024 and will submit the new PIPs for initial validation, with baseline results from calendar year (CY) 2024, in January 2025. The first annual validation ratings for the new PAHP PIPs will be reported in next year's annual EQR technical report. Table 2-1 summarizes the new PIP topics initiated by both PAHPs in SFY 2024.

Table 2-1—New PAHP PIP Topics Initiated in SFY 2024

New SFY 2024 PIP Topics
Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service
Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday

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

Table 2-2—SFY 2024 PAHP PIP Activities

PIP Activities and Milestones	Dates
LDH finalized selection of new PIP topics for the PAHPs	February 2024
LDH and HSAG met to discuss the PIP validation timeline and approach for the new PAHP PIP topics	February 2024
HSAG sent LDH-approved communication of the new PIP topics and validation timeline to the PAHPs	April 2024
The PAHPs worked on the design and baseline data collection for the new PIP topics	April–June 2024

In SFY 2025, the PAHPs 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 first annual validation of the new PAHP PIPs in April 2025, and the validation findings will be included in next year's EQR technical report.

Validation Results and Confidence Ratings

HSAG will complete validation of the SFY 2024 PAHP PIPs in April 2025, and the final validation results and ratings will be reported in next year's annual EQR technical report.

Performance Indicator Results

The PAHPs will report final CY 2024 indicator results for the baseline measurement period of both PIPs in January through March 2025. HSAG will validate the performance indicator results in SFY 2025, and the final performance indicator results for each PIP topic will be included in next year's annual EQR technical report.

Interventions

The PAHPs will report barriers and interventions for the new PIPs from January through March 2025. HSAG will complete the assessment of each PAHP's QI activities and interventions in SFY 2025, and HSAG's validation findings will be reported in next year's EQR technical report. Table 2-3 will include the barriers and interventions as documented by the PAHPs for the SFY 2025 PIP validation.

Table 2-3—Barriers and Interventions Reported by the PAHPs for each PIP

PAHP	PIP Topic	Barriers	Interventions
DQ	*Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service*	To be reported in SFY 2025	To be reported in SFY 2025
	Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday	To be reported in SFY 2025	To be reported in SFY 2025
MCNA	*Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service*	To be reported in SFY 2025	To be reported in SFY 2025
	Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday	To be reported in SFY 2025	To be reported in SFY 2025

Statewide PAHP Strengths, Opportunities for Improvement, and Recommendations

HSAG will report statewide strengths, opportunities for improvement, and recommendations for the PAHPs in next year's annual EQR technical report following HSAG's completion of the first annual validation cycle for the new PAHP PIPs in SFY 2025.

Methodology

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

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 PAHP processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each PAHP'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 PAHP conducted during the PIP. HSAG's scoring methodology evaluated whether the PAHP 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 PAHP 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

[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 13, 2024.

methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the PAHP 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 PAHPs with specific feedback and recommendations. The PAHPs 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 PAHP 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 PAHP. HSAG then identified common themes and the salient patterns that emerged across the PAHPs 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 PAHPs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of a PAHP'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 PAHP'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 2-4.

Table 2-4—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Topic	Quality	Timeliness	Access
Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service	✓		✓
Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday	✓	✓	✓

3. Validation of Performance Measures

Aggregate Results

Information Systems Standards Review

In 2024, HSAG administered an ISCA to the PAHPs to assess their IS and data processes. HSAG's review of the results found that both MCNA and DQ met the requirement of maintaining IS that collect, analyze, integrate, and report data that comply with LDH and federal reporting requirements. The systems also provided information on utilization, grievances, and appeals. The review comprised the following areas:

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

In 2024, LDH worked with Gainwell to calculate rates on the CMS-416 Line 12b performance measures based on data collected by the PAHPs during federal fiscal year (FFY) 2023 (October 1, 2022–September 30, 2023).

Performance Measures

Table 3-1 displays measure definitions, stewards, reporting periods, goals, and PAHP performance measure rates. Both PAHPs improved their performance on the CMS-416 12b measure based on rates calculated in 2024 compared to rates calculate in 2023; however, their performance measure rates fell below the LDH-established goal for the 2024 reporting period.

Table 3-1—PAHP Performance Measure

Measure	Steward	Reporting Period	Goal	MCNA Rate		DQ Rate	
				2023	2024	2023	2024
The percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 1-20, receiving at least 1 preventative dental service (CMS-416 Line 12b)	CMS	March 2024	46.63%	44.63%	45.36%	41.53%	42.89%

Statewide PAHP Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs statewide, the following strength was identified:

- Both PAHPs' rates on the CMS-416 12b performance measure increased from the prior reporting period (i.e., 2023), indicating that the PAHPs have put forth effort to improve access to preventative dental services. **[Quality, Timeliness, and Access]**

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

- Both PAHPs' rates on the CMS-416 12b performance measure fell below the LDH-established goal for the 2024 reporting period, suggesting that fewer than anticipated Medicaid members ages 1 to 20 years received a preventative dental service during the measurement period (i.e., October 1, 2022, to September 30, 2023). **[Quality, Timeliness, and Access]**

For the PAHPs statewide, the following recommendation was identified:

- HSAG recommends that the PAHPs work with dental service providers to ensure that Medicaid members have access to preventative service from "infancy and continuing to adolescence and beyond," as recommended by the American Academy of Pediatric Dentistry.[3-1] The PAHPs should educate Medicaid members about the importance of receiving preventative dental services and should consider targeted interventions based on identified disparities through ongoing data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code. **[Quality, Timeliness, and Access]**

[3-1] American Academy of Pediatric Dentistry. Periodicity of examination, preventative dental services, anticipatory guidance/counseling, and oral treatment for infants, children, and adolescents. Available at: https://www.aapd.org/globalassets/media/policies_guidelines/bp_periodicity.pdf. Accessed on: Dec 18, 2024.

Methodology

Objectives

In accordance with 42 CFR §438.330(c), states must require PAHPs 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 PAHP.
2. Determine the extent to which the specific performance measures calculated by the PAHP (or on behalf of the PAHP) 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

LDH selects a performance measure to evaluate the quality of care delivered by the PAHPs to Louisiana Medicaid members. The EPSDT measure assesses the effectiveness of state EPSDT programs for Medicaid-eligible individuals under the age of 21 years. This measure examines the number of children and adolescents who received health screenings and preventative health services, who were referred for corrective treatment, and who received dental treatment. LDH reports one performance measure for the dental program, CMS-416 12b.

LDH utilizes a contractor who produces the performance measure instead of the PAHPs self-reporting. The contractor produces rates for the CMS-416 12b measure.

Description of Data Obtained

HSAG obtained a copy of the CMS-416 12b information from LDH. Data were reported for the EPSDT CMS-416 12b measure, which assesses the total number of children and adolescents receiving preventative dental services.

How Data Were Aggregated and Analyzed

For SFY 2024, HSAG administered an ISCA to the PAHPs to assess their IS and data processes. The review comprised the following areas:

1. Enrollment System(s) and Processes
2. Claims/Encounter Data System(s) and Processes

3. Provider Data System(s) and Processes
4. Data Integration and Systems Architecture

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each PAHP provided to members, HSAG evaluated the results for each performance measure based on the LDH target to identify strengths and opportunities for improvement and determine whether each strength and weakness 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 PAHP's Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid PAHPs, 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 3-2.

Table 3-2—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
The percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 1-20, receiving at least 1 preventative dental service (CMS-416 Line 12b)	✓	✓	✓

4. Assessment of Compliance With Medicaid Managed Care Regulations

Aggregate Results

Federal regulations require the PAHPs 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 PAHP.

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

Standard Name	DQ			MCNA		
	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Enrollment and Disenrollment		**28.6%[2]**			**85.7%[2]**	
Member Rights and Confidentiality	74.3%			100%		
Member Information						
Emergency and Post-Stabilization Services	PAHPs are not responsible for inpatient services. 42 CFR 422.113 states that for the purpose of payment, post-stabilization care services begin at the time of admission. Therefore, this requirement is not applicable for the PAHPs.					
Availability of Services	72.7%			100%		
Assurances of Adequate Capacity of Services	86.8%			100%		
Coordination and Continuity of Care	The Coordination and Continuity of Care standard was not reviewed by the previous EQRO for the PAHPs in 2022 because the care coordination completed in dental services occurred from provider to provider and not at the health plan level; therefore, this standard was deemed not applicable to review at the health plan level.					
Coverage and Authorization of Services	96.3%			100%		
Provider Selection	98.3%			100%		
Subcontractual Relationships and Delegation		**83.3%[2]**			**83.3%[2]**	
Practice Guidelines	100%			100%		
Health Information Systems	100%			100%		
Quality Assessment and Performance Improvement Program	71.6%			100%		

Standard Name	DQ			MCNA		
	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Grievance and Appeal Systems	84.8%			100%		
Program Integrity	100%			100%		

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

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

Follow-Up on Previous Compliance Review Findings

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

DQ achieved compliance in 109 of 109 elements from the CAP review in year three. MCNA achieved compliance in one of one element from the CAP review in year three.

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

Statewide PAHPs Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs statewide, the following strength was identified:

- The PAHPs successfully remediated 110 of 110 elements, indicating that initiatives were implemented and demonstrated compliance with the requirements under review. **[Quality, Timeliness, and Access]**

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

- HSAG did not identify any opportunities for improvement.

For the PAHPs statewide, the following required actions and recommendations were identified:

- HSAG did not identify any required actions or recommendations.

Methodology

Standards

Table 4-2 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In year three (CY 2023), HSAG conducted a follow-up review of each PAHPs' CAPs from the previous CR. HSAG will conduct a comprehensive CR during CY 2025 to determine the extent to which the PAHPs 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	Year One (CY 2021)			Year Two (CY 2022)			Year Three (CY 2023)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard XII—Quality Assessment and Performance Improvement Program	✓	✓	✓						
Standard XIII—Grievance and Appeal Systems	✓	✓	✓						
Standard XIV—Program Integrity	✓	✓	✓						
CAP Review							✓	✓	✓

NA=not applicable for the PAHPs

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

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

Standard	Federal Requirements Included[1]	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement Program	42 CFR §438.330

Standard	Federal Requirements Included[1]	Standard	Federal Requirements Included
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.608

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

Objectives

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

- The PAHPs' 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 PAHPs 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 PAHPs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the PAHPs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess the PAHPs' 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.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2024.

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 PAHPs. • HSAG scheduled the virtual reviews to facilitate preparation for the reviews.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an PAHP pre-virtual review preparation session to describe HSAG's processes and allow the PAHPs the opportunity to ask questions about the review process and PAHP expectations. • HSAG confirmed a primary PAHP contact person for the review and assigned HSAG reviewers to participate. • During the PAHP pre-virtual review preparation session, HSAG notified the PAHPs 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 PAHP 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 PAHP'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 PAHP 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 PAHP's key staff members to obtain a complete picture of the PAHP'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 PAHP'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.

For this protocol activity,	HSAG completed the following activities:
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 PAHPs 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 PAHPs 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 PAHP 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 PAHP's performance in complying with each standard requirement.
- Scores assigned to the PAHP'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 PAHP'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 PAHP. HSAG then identified common themes and the salient patterns that emerged across PAHPs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the PAHPs, 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 PAHPs. Table 4-5 depicts assignment of the standards to the domains of care.

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

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

5. Validation of Network Adequacy

Aggregate Results

NAV Audit

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

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

HSAG assessed the dental PAHPs and found commonality among both that fell below the thresholds for distance requirements by provider type and urbanicity. Table 5-1 displays the common parishes between both PAHPs that fell below the required thresholds.

Table 5-1—Provider Types That Fell Below the Required Threshold Across Both Dental PAHPs, by Urbanicity

Provider Type	Urbanicity	Parishes Reported Non-Compliant for Both Dental PAHPs
Members in Urban Parishes Residing w/in 10 Miles of One Open Practice Main Dentist	Urban	Bossier; Calcasieu; DeSoto; Grant; Plaquemines; Saint Bernard; Saint Helena; Terrebone; Union
Members in Rural Parishes Residing w/in 30 Miles of One Open Practice Main Dentist	Rural	None
Members Residing w/in 60 Miles of One Endodontist (75%) or No More Than 75 Miles (100%)	Urban	Bossier; Caddo; Cameron; DeSoto; Lafayette
	Rural	Acadia; Beauregard; Bienville; Caldwell; Catahoula; Claiborne; East Carroll; Franklin; Jackson; Lincoln; Madison; Morehouse; Red River; Richland; Sabine; Tensas; Vermilion; West Carroll
Members Residing w/in 60 Miles of One Oral Surgeon (75%) or No More Than 75 Miles (100%)	Urban	Calcasieu; Cameron
	Rural	Beauregard
Members Residing w/in 60 Miles of One Orthodontist (75%) or No More Than 75 Miles (100%)	Urban	Grant
	Rural	Catahoula; Concordia; LaSalle; Natchitoches; Sabine; Vernon

Provider Type	Urbanicity	Parishes Reported Non-Compliant for Both Dental PAHPs
Members Residing w/in 60 Miles of One Periodontist (75%) or No More Than 75 Miles (100%)	Urban	Bossier; Caddo; Calcasieu; Cameron; DeSoto; Grant; Ouachita; Rapides; Union
	Rural	Acadia; Allen; Avoyelles; Beauregard; Bienville; Caldwell; Catahoula; Concordia; Evangeline; Franklin; Jackson; Jefferson Davis; LaSalle; Lincoln; Madison; Morehouse; Natchitoches; Richland; Sabine; Saint Landry; Tensas; Vermilion; Vernon; West Carroll; Winn
Members Residing w/in 60 Miles of One Prosthodontist (75%) or No More Than 75 Miles (100%)	Urban	Bossier; Caddo; Calcasieu; Cameron; DeSoto; Grant; Ouachita; Rapides; Union
	Rural	Allen; Avoyelles; Beauregard; Bienville; Caldwell; Catahoula; Claiborne; Concordia; East Carroll; Evangeline; Franklin; Jackson; LaSalle; Lincoln; Madison; Morehouse; Natchitoches; Red River; Richland; Sabine; Vernon; Webster; West Carroll; Winn

Statewide PAHP Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs statewide, the following strengths were identified:

- Overall, the PAHPs 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 PAHPs statewide, the following opportunities for improvement were identified:

- Both PAHPs reported the 834 file is considered the source of truth regardless of when the PAHP is informed of a change in member demographic information. **[Quality, Timeliness, and Access]**

For the PAHPs statewide, the following recommendations were identified:

- HSAG recommends that the PAHPs explore their system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than the information provided through the 834 file. **[Quality, Timeliness, and Access]**

Methodology

Objectives

In accordance with 42 CFR §438.350(a) states that contract with MCOs, PIHPs, and PAHPs, collectively referred to as "MCEs," 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 PAHPs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by LDH.

Technical Methods of Data Collection

HSAG collected network adequacy data from the PAHPs via a secure file transfer protocol (SFTP) site and via virtual network adequacy validation (NAV) audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[5-1]

HSAG conducted a virtual review with the PAHPs that included team members from the EQRO, PAHP 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 PAHP 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

[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 18, 2024.

- Network adequacy source data PSV and results
- Closing conference

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

Description of Data Obtained

HSAG prepared a document request packet that was submitted to each PAHP 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 PAHP'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 PAHPs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the PAHPs 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

HSAG assessed each PAHP'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 PAHP'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 PAHP used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

How Conclusions Were Drawn

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 5-2.

Table 5-2—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 PAHP'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 5-3 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-3—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 PAHP provide a root cause analysis of the finding.
- Working with the PAHP 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 PAHP'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 PAHPs, 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 5-4.

Table 5-4—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. PAHP Aggregate Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2024 to comprehensively assess the PAHPs' performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides the PAHPs' aggregate strengths, opportunities for improvement, and recommendations in Table 6-1 through Table 6-3.

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

Overall PAHP Strengths	
Quality, Timeliness, and Access	• Both PAHPs' rates on the CMS-416 12b performance measure increased from the prior reporting year, indicating that the PAHPs have put forth effort to improve access to preventative dental services. • DQ demonstrated strength through its effective internal data validation capabilities, and its ability to maintain accurate and complete provider information. • MCNA demonstrated strength by establishing a robust process to keep providers up to date through quarterly provider surveys, provider on-site visits and education, the credentialing process, and quarterly monitoring of the multiple sanction/exclusion lists.

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

Overall PAHP Opportunities for Improvement	
Quality, Timeliness, and Access	• LDH provided 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. • Both PAHPs fell below the thresholds for distance requirements by provider type and urbanicity. • Both PAHPs' rates on the CMS-416 12b performance measure fell below the LDH-established goal for the 2024 reporting period, suggesting that fewer than anticipated Medicaid members 1 to 20 years old received a preventative dental service during the measurement period (i.e., October 1, 2022, to September 30, 2023).

Table 6-3—Recommendations

Overall PAHP Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
HSAG recommends that LDH review its reporting template against the contractual language to align with and more accurately reflect the LDH-desired reporting information captured by the plans and to ensure consistent reporting.	Goal 1: Ensure access to care to meet enrollee needs
HSAG recommends that the PAHPs explore their system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than the information provided through the 834 file.	Goal 1: Ensure access to care to meet enrollee needs
HSAG recommends that the PAHPs conduct a root cause analysis or focused study to determine why some members were not always receiving at least one preventative dental service or dental visit during the year. Upon identification of a root cause, the PAHPs should implement appropriate interventions to continue to improve performance related to the CMS-416 12b and *Annual Dental Visit* performance measures.	Goal 1: Ensure access to care to meet enrollee needs Goal 4: Promote wellness and prevention
HSAG recommends that DQ conduct an in-depth review of provider types for which GeoAccess standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.	Goal 1: Ensure access to care to meet enrollee needs

7. Follow-Up on Prior Year's Recommendations

Table 7-1 through Table 7-8 contain a summary of the follow-up actions that the PAHPs completed in response to the EQRO's SFY 2023 recommendations. Furthermore, HSAG assessed the PAHPs' approach to addressing the recommendations. Please note that the responses in this section were provided by the PAHPs and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

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

High indicates *all* of the following:

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

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

Medium indicates one or more of the following:

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

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

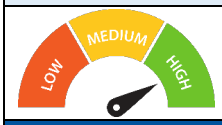
Low indicates one or more the following:

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

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

DQ

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

1. Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects:
The PAHPs should revisit PIP root cause analyses identifying barriers to improving access to dental services and use intervention-specific evaluation results to guide decisions about continuing, revising, or discontinuing interventions to promote effective resource use and achievement of improvement goals.
Response
Describe initiatives implemented based on recommendations: Barrier analysis and fishbone diagram was reviewed to determine effectiveness of interventions. Upon completion, outreach and education on sealants was continued as well as importance of preventive dental care.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): DQ continues to see improvement in sealant application and preventive care.
Identify any barriers to implementing initiatives: Members not taking action based on sealant education provided or preventive care. Providers not always applying sealants for members who meet criteria.
Identify strategy for continued improvement or overcoming identified barriers: Continue to emphasize importance and purpose of preventive care and sealants to members and explore alternative ways of communicating education. Emphasizing importance of sealants to providers.
HSAG Assessment

Recommendations
The PAHPs should continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

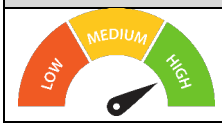
1. Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects:
Response
Describe initiatives implemented based on recommendations: Educational outreach on sealants and along with emphasizing importance of sealant application to providers. Educational outreach also included initiatives focused on the importance of routine preventive care.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): DQ continues to see improvement in sealant application and preventive care.
Identify any barriers to implementing initiatives: Members not taking action based on sealant education provided or preventive care. Providers not always applying sealants for members who meet criteria.
Identify strategy for continued improvement or overcoming identified barriers: Continue to emphasize importance and purpose of preventive care and sealants to members and explore alternative ways of communicating education. Emphasizing importance of sealants to providers.
HSAG Assessment


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

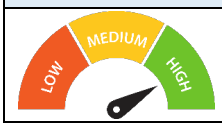
2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
The PAHPs should conduct a root cause analysis or focused study to determine why some members were not always receiving at least one preventive dental service or dental visit during the year. Upon identification of a root cause, the PAHPs should implement appropriate interventions to continue to improve performance related to the CMS-416 12b and *Annual Dental Visit* performance measures.
Response
Describe initiatives implemented based on recommendations: Root cause analysis was done to determine potential causes for members not receiving at least one preventive dental service annually. Initiatives to address oral health literacy were implemented to increase ADV measures including educational outreach, targeted outreach to members overdue for dental visit, partnerships and participation in community events to increase awareness on the importance of oral health.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Data show improvement in the number of members receiving dental services.
Identify any barriers to implementing initiatives: Member not showing up to appointments or responding to outreach initiatives.
Identify strategy for continued improvement or overcoming identified barriers: Continue current approach and explore alternative ways of communicating to members on the importance of routine dental care.
HSAG Assessment


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

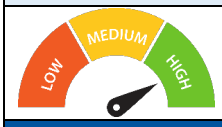
Recommendations
None identified.

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

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
To improve access to care, the PAHPs should conduct an in-depth review of provider types for which Geo Access standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.
Response
Describe initiatives implemented based on recommendations: The Access gaps were filled by continuous provider recruitment and education. DentaQuest provided providers with the decision tool to aid in submitting PAs and claims. This act allowed 35 providers to join the network and 6 Oral Surgeons in June of 2024.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): 35 general providers have joined the Network and 6 specialists.
Identify any barriers to implementing initiatives: Due to the high turnover of office staff, training and retraining has become a necessary component
Identify strategy for continued improvement or overcoming identified barriers: The strategy has been to have the representatives visit all providers offices, to include non-Medicaid, with hopes of growing the Network especially in areas that has little to no providers. The Reps has visited a total of 400 offices to date and will continue in this vein to ensure Network adequacy.
HSAG Assessment


MCNA

Table 7-5—Follow-Up on Prior Year's Recommendations for PIPs

1. Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects:
The PAHPs should revisit PIP root cause analyses identifying barriers to improving access to dental services and use intervention-specific evaluation results to guide decisions about continuing, revising, or discontinuing interventions to promote effective resource use and achievement of improvement goals.
Response
Describe initiatives implemented based on recommendations: MCNA developed additional BI tools throughout 2024 and conducted quarterly rapid cycle analysis specific to each intervention. These results and subsequent analysis were presented to our quarterly Quality Improvement Committee with minutes shared with LDH. MCNA also participated in national efforts to identify best practices for driving quality improvement, including CMS' Affinity Group targeting improved oral health.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): MCNA continued to demonstrate moderate improvement in each of our interventions. Year-end results are not yet available to determine their overall effectiveness.
Identify any barriers to implementing initiatives: There were no barriers to implementing targeted interventions.
Identify strategy for continued improvement or overcoming identified barriers: MCNA will leverage our strength in business intelligence and participation in local and national quality improvement forums to continue our momentum in identifying and implementing new and robust intervention strategies. We will continue use of rapid cycle analysis to assess the effectiveness of specific interventions and make swift changes to those that are not demonstrating targeted improvement.
HSAG Assessment

Recommendations
The PAHPs should continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.
Response
Describe initiatives implemented based on recommendations: MCNA has continued all past interventions for completed PIPs. All interventions are utilized state-wide and across all membership. These interventions were analyzed for use in our new PIP topics as defined by LDH and included in our recently submitted PIP summary.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): MCNA has continued to see improvement with each previously targeted intervention.
Identify any barriers to implementing initiatives: There were no barriers identified to continue interventions and conducting ongoing analysis.

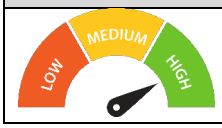
1. Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects:
Identify strategy for continued improvement or overcoming identified barriers: MCNA will continue to present quarterly analysis and intervention success through our Quality Improvement Committee. Interventions that warrant retirement will be replaced with newly designed interventions based upon qualitative and quantitative data relative to the quality improvement target. Any pilot-test interventions will be spread beyond a narrow focus once effectiveness have been confirmed.
HSAG Assessment


Table 7-6—Follow-Up on Prior Year's Recommendations for Performance Measures

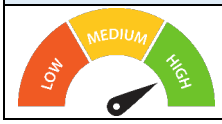
2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
The PAHPs should conduct a root cause analysis or focused study to determine why some members were not always receiving at least one preventive dental service or dental visit during the year. Upon identification of a root cause, the PAHPs should implement appropriate interventions to continue to improve performance related to the CMS-416 12b and *Annual Dental Visit* performance measures.
Response
Describe initiatives implemented based on recommendations: MCNA utilized our member advocate and outreach specialists in the field to collect member specific root causes for members not seeking an annual dental visit or receiving preventive dental services. We complimented this information with feedback from our Dental Advisory Committee regarding trends they see relative to our membership missing appointments. Trends in root causes include Social Determinants of Health and lack of oral health literacy. MCNA developed new BI tools to identify areas most at risk of threat for either of these two root causes and created relationships with key Community Based Organizations (CBOs) to help mitigate the existing barriers. These efforts were in addition to previous interventions already deemed successful and continue to be ongoing.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): MCNA's preventive services rate in 2024 has already surpassed that achieved in 2024.
Identify any barriers to implementing initiatives: There are no barriers to implementing interventions.
Identify strategy for continued improvement or overcoming identified barriers: MCNA will continue to study Parish specific and neighborhood specific results to assess success in eliminating SDOH. We will also continue to target interventions and assess both annual dental visit rates and preventive services rates in our 2025 PIP using rapid cycle analysis. All ongoing analysis and results will be documented through our Quality Improvement Committee minutes and shared with LDH.
HSAG Assessment


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

Recommendations
None identified.

Table 7-8—Follow-Up on Prior Year's Recommendations for Network Adequacy

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
To improve access to care, the PAHPs should conduct an in-depth review of provider types for which GeoAccess standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.
Response
Describe initiatives implemented based on recommendations: MCNA works diligently to increase access to care through our ongoing approach to provider recruitment. MCNA deploys multiple strategies to expand available access points in rural and Dental Health Professional Shortage Areas (HPSAs). The Network Development team conducts an in-depth review of provider types for which GeoAccess standards were not met and use analysis results to guide contracting efforts. Some of our key strategies include expanding the network to include providers in bordering states, pursuing out-of-network arrangements, and relaxing administrative requirements such as reducing the number of Prior Authorizations required for certain procedures. MCNA's best practice approach for network development begins with boots on the ground, grass roots community mapping of our prospective states. Our Network Development team assess the availability of dentists, dental specialists, FQHCs, RHCs, schools of dentistry, IHCPs, mobile dental clinics, and providers offering school-based services by researching for available providers via LA State Board of Dentistry, NPES NPI Registry, LA Dental Association, or our own Dental Advisory Committee.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The network continues to grow as a result of grassroot efforts in recruitment and using the established relationships the Provider Relations team has with the provider community.
Identify any barriers to implementing initiatives: MCNA will continue to monitor for improvement as our network continues to grow, however, shortage areas continue to be a challenge and specialists do not open new practices in shortage areas. In areas where there may be available specialists, they typically do not contract for government programs.
Identify strategy for continued improvement or overcoming identified barriers: MCNA continues to explore strategies to recruit specialists in shortage areas and we update our search for providers that may move into these areas on a frequent basis. We do this by updating our provider listings using resources such as the Louisiana State Board of Dentistry, NPES NPI Registry, LA Dental Association, or our own Dental Advisory Committee that help identify providers that may be willing to move into shortage areas.
HSAG Assessment


Appendix A. PAHP Response to the Health Disparities Focus Study

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

For the annual EQR technical report, HSAG requested information from each PAHP regarding its activities related to identifying and/or addressing gaps in health outcomes and/or healthcare among its Medicaid population according to at-risk characteristics such as race, ethnicity, gender, and geography. The PAHPs were asked to respond to the following questions for the period of July 1, 2023, through June 30, 2024:

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

DQ Verbatim Response:

DentaQuest (DQ) implemented the following initiatives during July 1, 2023, and June 30, 2024, to reduce disparities in the Medicaid population. Oral health literacy in the Medicaid population is poor thereby affecting utilization of dental services and ultimately impact health outcomes. To improve oral health literacy, DQ has implemented a range of supports, education, and incentives to educate enrollees on the importance of oral health and most importantly arm them with the skills and knowledge to effectively manage their oral health.

All members receive a welcome call and a health risk assessment within 30 days of enrollment. During this welcome call, enrollees are educated on their dental benefit, the importance of routine dental care, and they are provided with contact information should they need any additional support. The secondary component of the welcome call is the health risk assessment (HRA). The HRA consists of a series of questions that identify areas where the member may be at risk and require more individual support. Responses indicating enrollee has poor oral health, dental pain, chronic medical conditions or needs assistance with transportation, housing, food and/or utilities indicate the enrollee may be at risk. Once it has been identified that an enrollee may be at risk, an outreach call is placed by a Care Coordinator who conducts a more comprehensive assessment to determine the level of support the enrollee needs. Based on the results of this assessment, enrollees are placed into care coordination or case management. Enrollees who require short term support to improve their functional capability and minimize barriers to care receive care coordination. Those members who require long term support are enrolled in the Case

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

Management program. Case Management provides high risk enrollees with long term additional supports to promote enrollee self-management, treatment adherence and improved oral health.

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

Research shows dental caries is the most common chronic disease in children in the United States. Evidence-based clinical recommendations recommend that sealants are effective in reducing the incidence of carious lesions in permanent molars. To help combat dental caries and align with the national average for sealants, a program called Healthy Behaviors was developed. In the Healthy Behaviors program, children receive an oral health kit when they have their adult molars sealed. In addition to this program, DQ conducted an analysis of disproportionate utilization to better understand the sealant usage for children who turned 10 years of age during the measurement year. This analysis stratified the data by race and geography and was used to develop targeted interventions for the disparate populations to improve the percentage of members receiving sealants on a permanent tooth. Interventions for this population included a reminder call and an outreach call to assist with appointment scheduling.

Medicaid enrollees are at higher risk for developing Early Childhood Caries (ECC), a severe form of caries (cavities), that affects the primary teeth of infants, toddlers, and preschool children. ECC can progress rapidly and, if left untreated, may result in pain and infection. The Healthy Beginnings program promotes prevention and early detection of ECC by educating parents/caregivers on oral health, routine dental visits and proper dental care for infants and children. Parents/caregivers of enrollees ages 0-2 will receive educational messaging at birth and first and second birthday. Parents of these young enrollees also have access to information and resources available to reinforce the initial education. In addition to the education, parents/guardians are provided contact information to help access a provider.

The Member Outreach team networks with community partners and identifies opportunities to collaborate. These collaborations could include, attending events and/or providing education to specialty groups. Some of the targeted initiatives the outreach team participated in this year were with Black and Hispanic groups, special needs populations (autism) and in rural communities. These partnerships help reinforce the importance of oral health and form positive partnerships that extend into the future for at risk populations and to help decrease health disparities in these groups.

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

MCNA Verbatim Response:

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

Corporate level activities to date include:

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

At the local level, MCNA has:

- Worked with various school districts to help ensure children have needed back to school supplies by participating in back-to-school events
- Attended meetings with various health care management organizations to help plan community events to provide dental education to the public
- Participated in health fairs and other community events
- Attended Food Pantry days with the various ministries throughout the state
- Attended and volunteered at the LA Mission of Mercy
- Collaborated with community health care centers to provide information and education
- Provided education and oral hygiene items to participants at homeless shelters

To remove language barriers for our diverse population and meet the cultural needs of our members, MCNA deployed text messages that were delivered to members in their primary language for the top five languages spoken including English, Spanish, French, Vietnamese, and Arabic.

- For the time period of July 1, 2023, through June 30, 2024, MCNA deployed 40,136 preventive text messages, (one per household) advising the parent/guardian to schedule an appointment for preventive dental care.
    - Of the 40,136 members who received a text, 11,427 (28%) members visited their primary care dentist and 10,431 (91%) of those members received a preventive service within 60 days post receipt of a text message.

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

Lastly, the Practice Site Performance Summary (PSPS) reports were distributed to 1,445 providers. This tool is designed to assist providers in understanding how their clinical and operational performance compares with that of their peers. A preventive services section of the report includes the percent of assigned children receiving a preventive visit in accordance with the American Association of Pediatric Dentistry's Periodicity Schedule. Each provider receives a detailed quarterly report that outlines individual provider performance with respect to claims, prior authorizations, and preventive services in comparison to goals and peer groupings.