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

External Quality Review Technical Report

for

Louisiana Healthcare Connections

February 2025

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Acknowledgments and Copyrights

1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

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

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 16, 2024.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 16, 2024.

health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2024 (July 1, 2023–June 30, 2024) are displayed in Table 1-1. Of note, no MCEs are exempt from EQR.

Table 1-1—Louisiana's Medicaid MCEs

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

Scope of External Quality Review

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

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

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

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

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

Report Purpose

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

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

Definitions

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

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

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

Methodologies

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

Aggregating and Analyzing Statewide Data

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

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

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

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

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

Louisiana's Medicaid Managed Care Quality Strategy

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

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

Goals and Objectives

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

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

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

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

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

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

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

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

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

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

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

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

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

Recommendations

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

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

- HSAG recommends that LDH report rates for the following measures:
  - 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	LDH will continue to meet and collaborate with the MCOs related to

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

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

Overview of External Quality Review Findings

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

Validation of Performance Improvement Projects

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

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

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

Validation of Performance Measures

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

Information Systems Capabilities Assessment

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

HEDIS—Quality, Timeliness, and Access

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

Of the 278 HEDIS measures/measure indicators with an associated benchmark, LHCC had 190 indicators that performed greater than the NCQA national 50th percentile benchmark, 85 indicators that performed lower than the NCQA national 50th percentile benchmark, and three indicators that were not compared to the NCQA national 50th percentile benchmark because the reported rates were *Not Applicable (NA)* (i.e., small denominator), *NB* (i.e., no benefit), or *NR* (i.e., not reported). Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG reviewed the corrective action plans (CAPs) that LHCC prepared to remediate any deficiencies identified during the 2023 CR. HSAG and LDH evaluated the sufficiency of the CAPs. LHCC achieved compliance in three of three elements from the 2023 CAPs. LHCC demonstrated that it successfully remediated all three 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

Provider Directory Validation

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

Table 1-4—Summary of PDV Findings

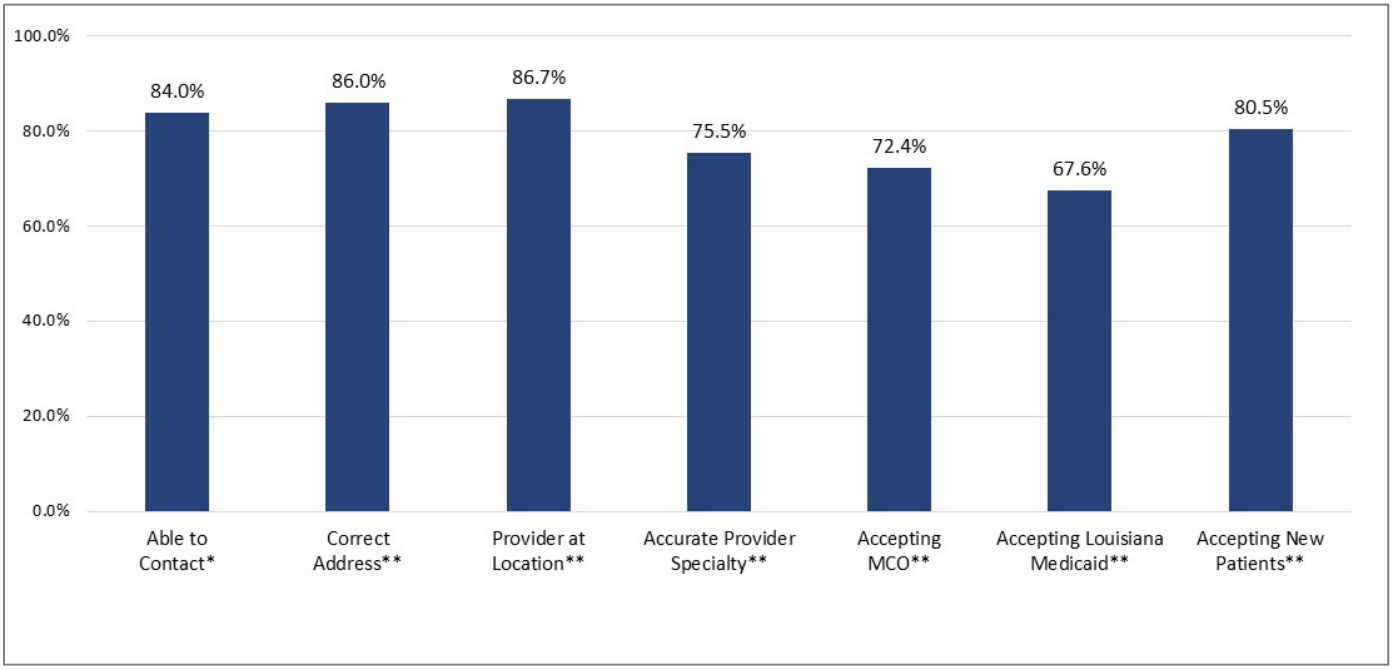
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 67.6 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 72.4 percent of providers accepted the requested MCO.

Concerns	Findings
Provider's specialty in the provider directory was incorrect.	Overall, 75.5 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall acceptance of new patients was low.	Overall, 80.5 percent of providers accepted new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews.
Address information was incorrect.	Overall, 86.0 percent of respondents reported that LHCC's provider directory reflected the correct address.
Affiliation with the sampled provider was low.	Overall, 86.7 percent of the locations confirmed affiliation with the sampled provider.

While the overall PDV response rate was relatively high at 84.0 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of Louisiana Medicaid acceptance, LHCC acceptance, and the provider's specialty exhibited the lowest match rates, with all indicators exhibiting a match rate below 87.0 percent.

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

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



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

LHCC's weighted PDV compliance scores by specialty type ranged from 32.3 percent (behavioral health) to 73.0 percent (pediatrics).

Provider Access Survey

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

Table 1-5—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 18.1 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 26.8 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of Louisiana Medicaid was low.	Overall, 28.3 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 29.9 percent of providers accepted the requested MCO.
Provider's specialty in the provider data was inaccurate.	Overall, 37.8 percent of providers confirmed the specialty listed in the provider data was accurate.
Address information was inaccurate.	Overall, 72.4 percent of locations confirmed the address listed in the provider data was accurate.

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

Table 1-6—Provider Access Survey Call Outcomes

Specialty	Able to Contact[1]	Correct Address[2]	Offering Services[2]	Accepting MCO[2]	Accepting Medicaid[2]	Accepting New Patients[2]	Confirmed Provider[2]
Total	**63.5%**	**72.4%**	**37.8%**	**29.9%**	**28.3%**	**26.8%**	**18.1%**
Primary Care	58.3%	74.3%	42.9%	31.4%	28.6%	25.7%	11.4%
Pediatrics	80.0%	84.4%	56.3%	50.0%	46.9%	43.8%	37.5%
Obstetricians/ Gynecologists (OB/GYNs)	60.0%	75.0%	41.7%	33.3%	33.3%	33.3%	25.0%
Endocrinologists	60.0%	66.7%	33.3%	33.3%	33.3%	33.3%	33.3%
Dermatologists	40.0%	62.5%	37.5%	0.0%	0.0%	0.0%	0.0%
Neurologists	70.0%	64.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Orthopedic Surgeons	70.0%	57.1%	21.4%	21.4%	21.4%	21.4%	0.0%

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

LHCC's weighted provider access survey compliance scores by specialty type ranged from 11.7 percent (dermatologists) to 45.0 percent (pediatrics). LHCC's after-hours weighted provider access survey compliance scores by specialty type ranged from 6.7 percent (endocrinologists) to 33.3 percent (orthopedic surgeons).

NAV Audit

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

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

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

Provider Type	Urbanicity
Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine and Physician Extenders)	Rural
Pediatrics (Family/General Practice; Internal Medicine and Physician Extenders)	Rural
Pharmacy	Rural
Hemodialysis Centers	
Other Specialty Care	Rural
Psychiatric Residential Treatment Facilities (PRTFs), PRTF (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	Urban
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban
	Rural

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

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

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

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	99.0%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	99.0%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	99.0%

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared LHCC's 2024 achievement scores to its corresponding 2023 achievement scores and the 2024 NCQA national averages to determine whether there were statistically significant differences. Overall, LHCC's 2024 adult achievement score was statistically significantly higher in 2024 than 2023 for *Getting Needed Care*. Furthermore, LHCC's 2024 adult achievement score was statistically significantly higher than the 2024 NCQA national average for *Rating of Personal Doctor*.

Behavioral Health Member Satisfaction Survey

HSAG compared LHCC's 2024 achievement scores to the 2024 Healthy Louisiana statewide average (SWA) and 2023 scores to determine whether there were statistically significant differences. Overall, LHCC's 2024 adult and child scores were not statistically significantly different than the 2024 Healthy Louisiana SWA on any of the measures. Several measures had less than 100 respondents. LHCC should focus on increasing response rates to the behavioral health member satisfaction survey for its adult and child populations.

Health Disparities Focus Study

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

Case Management Performance Evaluation

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

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

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

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

Quality Rating System

Figure 1-2 displays the 2024 Health Plan Report Card, which presents the 2024 rating results for each MCO. The 2024 Health Plan Report Card shows that, for the Overall Rating, LHCC received 3.5 stars. LHCC received 5.0 stars for the Satisfaction with Plan Physicians subcomposite and 4.0 stars for the Satisfaction with Plan Services and Diabetes subcomposites, demonstrating strength for LHCC in these areas. LHCC also received 2.0 stars for the Children/Adolescent Well-Care and Reduce Low Value Care subcomposites as well as 1.0 star for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for improvement for LHCC in these areas.

Figure 1-2—2024 Health Plan Report Card

Issued 08/2024

Healthy Louisiana

2024 HEALTH PLAN REPORT CARD

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

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

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

Continued on next page...

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

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

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

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

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

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

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

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

2. Validation of Performance Improvement Projects

Results

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

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

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

*PIP to be validated during SFY 2025.

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

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

Table 2-2—SFY 2024 MCO PIP Activities

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

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

Validation Results and Confidence Ratings

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

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

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

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

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

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

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

Performance Indicator Results

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

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

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 1,673 D: 9,156	18.27 %	N: 1,717 D: 8,592	19.98%▲			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 3,551 D: 9,156	38.78 %	N: 3,444 D: 8,592	40.08%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 401 D: 1,804	22.23 %	N: 349 D: 1,593	21.91%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 679 D: 1,804	37.64 %	N: 598 D: 1,593	37.54%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 462 D: 2,912	15.87 %	N: 309 D: 2,336	13.23%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 759 D: 2,912	26.06 %	N: 509 D: 2,336	21.79%			*Not Assessed*

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

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

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

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 150,623 D: 336,359	44.78%	N: 124,270 D: 270,672	45.91% ▲	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 129,645 D: 336,359	38.54%	N: 107,600 D: 270,672	39.75% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 41,242 D: 119,944	34.38%	N: 33,099 D: 93,939	35.23% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 79,610 D: 155,173	51.30%	N: 65,336 D: 122,176	53.48% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 10,501 D: 25,647	40.94%	N: 11,914 D: 28,898	41.23%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 19,270 D: 35,595	54.14%	N: 13,921 D: 25,659	54.25%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 35,546 D: 119,944	29.64%	N: 28,617 D: 93,939	30.46% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 67,955 D: 155,173	43.79%	N: 56,347 D: 122,176	46.12% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 8,796 D: 25,647	34.30%	N: 10,044 D: 28,898	34.76%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 17,348 D: 35,595	48.74%	N: 12,592 D: 25,659	49.07%	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 17,507 D: 59,394	29.48%	N: 12,340 D: 48,927	25.22%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 14,427 D: 59,394	24.29%	N: 10,043 D: 48,927	20.53%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 12,916 D: 99,784	12.94%	N: 9,492 D: 85,725	11.07%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 9,712 D: 99,784	9.73%	N: 7,248 D: 85,725	8.45%	*Not Assessed*

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

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

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

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 1,612 D: 14,780	10.91%	N: 2,014 D: 15,383	13.09% ▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,205 D: 19,605	6.15%	N: 1,448 D: 19,548	7.41% ▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 858 D: 22,133	3.88%	N: 946 D: 22,215	4.26% ▲			*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 3,675 D: 56,518	6.50%	N: 4,408 D: 57,146	7.71% ▲			*Not Assessed*

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

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

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

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 46,964 D: 89,499	52.47%					*Not Assessed*

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

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

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

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 10,679 D: 14,450	73.90%					*Not Assessed*
Persons screened for HIV during the measurement	N: 7,803	29.67%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
year among persons with past or present (injection) drug use	D: 26,295						
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 20,917 D: 51,895	40.31%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 42,423 D: 163,580	25.93%					*Not Assessed*

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

Interventions

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

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

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

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

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

For LHCC, the following opportunities for improvement were identified:

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

For LHCC, the following recommendations were identified:

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

Methodology

Objectives

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

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

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

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

Technical Methods of Data Collection

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

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

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

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

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

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

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

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

How Conclusions Were Drawn

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

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

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

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

3. Validation of Performance Measures

Results

Information Systems Standards Review

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

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

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

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

Performance Measures

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

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

HEDIS Measure	MY 2022	MY 2023	SWA
Follow-Up After Hospitalization for Mental Illness			
Within 7 Days of Discharge	18.74%	20.70%	**20.67%**
Within 30 Days of Discharge[1]	39.48%	41.60%	**39.62%**
Follow-Up After Emergency Department Visit for Mental Illness			
Within 7 Days of Discharge	22.54%	22.39%	**22.26%**
Within 30 Days of Discharge[1]	37.76%	38.24%	**36.83%**

HEDIS Measure	MY 2022	MY 2023	SWA
Follow-Up After Emergency Department Visit for Substance Use[B]			
Within 7 Days of Discharge	15.88%	13.42%	**13.46%**
Within 30 Days of Discharge[I]	26.05%	21.89%	**21.75%**
Plan All-Cause Readmissions*			
Observed Readmissions (Numerator/Denominator)	9.52%	10.06%	**10.13%**
Expected Readmissions Rate	9.40%	9.62%	**9.77%**
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.0122	1.0460	**1.0368**
Depression Screening and Follow-Up for Adolescents and Adults			
Depression Screening (Total)	0.00%	NR	**1.06%**
Follow-Up on Positive Screen (Total)	0.00%	NR	**62.50%**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.52%	83.89%	**84.36%**
Diabetes Monitoring for People With Diabetes and Schizophrenia	67.44%	73.32%	**72.29%**
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	76.84%	81.91%	**81.53%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing	52.04%	52.36%	**54.92%**
Cholesterol Testing	25.42%	25.93%	**28.09%**
Blood Glucose and Cholesterol Testing	24.73%	24.86%	**27.21%**
Lead Screening in Children	61.64%	68.13%	**66.40%**
Childhood Immunization Status			
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	68.13%	70.45%	**71.31%**
Polio Vaccine, Inactivated (IPV)	89.05%	87.42%	**87.17%**
Measles, Mumps, and Rubella (MMR)	85.16%	86.33%	**86.06%**
Haemophilus Influenzae Type B (HiB)	84.67%	85.92%	**85.66%**
Hepatitis B	91.00%	90.35%	**89.20%**
Varicella-Zoster Virus (VZV)	85.40%	86.44%	**86.30%**
Pneumococcal Conjugate	66.91%	69.52%	**70.65%**
Hepatitis A	80.78%	83.73%	**83.82%**
Rotavirus	67.15%	63.61%	**63.96%**
Influenza	27.98%	20.46%	**21.26%**
Combination 3[I]	61.80%	63.80%	**64.96%**
Combination 7	51.82%	52.45%	**53.34%**
Combination 10	20.92%	15.61%	**16.16%**

HEDIS Measure	MY 2022	MY 2023	SWA
Immunizations for Adolescents			
Meningococcal	83.76%	86.60%	**85.85%**
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	84.46%	87.10%	**86.29%**
Human Papillomavirus (HPV)	37.60%	39.18%	**41.77%**
Combination 1	83.59%	86.36%	**85.64%**
Combination 2[I]	37.27%	38.87%	**41.53%**
Colorectal Cancer Screening[I]	34.06%	44.28%	**43.44%**
Flu Vaccinations for Adults Ages 18 to 64	35.14%	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
Body Mass Index (BMI) Percentile Documentation	60.58%	81.51%	**80.09%**
Counseling for Nutrition	57.18%	70.56%	**64.97%**
Counseling for Physical Activity	51.58%	59.12%	**57.89%**
HIV Viral Load Suppression[B, I]	79.78%	81.99%	**82.26%**
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	27.47%	27.18%	**26.35%**
Chlamydia Screening in Women			
Total	63.84%	67.37%	**65.84%**
Breast Cancer Screening	55.74%	—	—
Controlling High Blood Pressure[I]	55.23%	60.34%	**60.47%**
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	80.41%	81.94%	**82.74%**
Statin Adherence 80%—Total	73.30%	74.18%	**66.40%**
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes			
Poor HbA1c Control (>9.0%)[*,I]	45.99%	31.63%	**29.55%**
HbA1c Control (<8.0%)	44.77%	61.56%	**63.65%**
Eye Exam for Patients With Diabetes	53.04%	59.37%	**55.06%**
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)	50.61%	63.02%	**65.25%**
Pharmacotherapy for Opioid Use Disorder	34.90%	34.11%	**29.53%**
Initiation and Engagement of Substance Use Disorder (SUD) Treatment			
Initiation of SUD Treatment	55.86%	49.81%	**57.95%**
Engagement of SUD Treatment	21.55%	15.87%	**24.37%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	60.10%	61.74%	**63.06%**

HEDIS Measure	MY 2022	MY 2023	SWA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.14%	60.69%	**55.72%**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication			
Initiation Phase	42.92%	44.21%	**45.52%**
Continuation and Maintenance Phase	54.84%	51.43%	**54.23%**
Antidepressant Medication Management			
Effective Acute Phase Treatment	56.85%	59.73%	**57.61%**
Effective Continuation Phase Treatment	39.76%	42.60%	**39.77%**
Appropriate Treatment for Children With Upper Respiratory Infection	79.95%	80.12%	**80.50%**
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	52.58%	51.12%	**51.81%**
Use of Imaging Studies for Low Back Pain[B]	71.47%	69.11%	**69.31%**
Non-Recommended Cervical Screening in Adolescent Females[*]	2.07%	2.05%	**1.85%**
Cervical Cancer Screening[I]	56.69%	58.64%	**53.47%**
Asthma Medication Ratio			
5–11 Years	—	79.44%	**76.33%**
12–18 Years	—	74.41%	**69.59%**
19–50 Years	—	72.27%	**68.05%**
51–64 Years	—	69.43%	**67.00%**
Total	—	74.21%	**70.18%**
Topical Fluoride for Children			
1–2 Years	—	6.54%	**4.76%**
3–4 Years	—	10.52%	**6.32%**
Total	—	8.55%	**5.56%**
Oral Evaluation, Dental Services			
0–2 Years	—	NA	**NA**
3–5 Years	—	NA	**NA**
6–14 Years	—	NA	**NA**
15–20 Years	—	NA	**NA**
Total	—	NA	**NA**

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

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

HEDIS Measure	MY 2022	MY 2023	SWA
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	72.25%	76.80%	**71.25%**
45–64 Years	81.11%	84.67%	**80.87%**
65 Years and Older	78.18%	82.46%	**79.46%**
Total	74.69%	79.11%	**74.25%**
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	81.51%	78.83%	**82.12%**
Postpartum Care	75.18%	77.62%	**77.27%**

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

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

HEDIS Measure	MY 2022	MY 2023	SWA
Well-Child Visits in the First 30 Months of Life			
First 15 Months	58.57%	63.17%	**64.44%**
15 Months–30 Months	63.41%	70.49%	**70.10%**
Child and Adolescent Well-Care Visits			
3–11 Years	55.24%	59.98%	**57.47%**
12–17 Years	52.49%	56.83%	**54.10%**
18–21 Years	27.83%	32.59%	**29.30%**
Total	49.12%	54.23%	**51.39%**
Ambulatory Care			
Outpatient Visits/1,000 Member Years	4932.72	5,253.10	**4,958.45**
Emergency Department Visits/1,000 Member Year *	736.87	762.05	**735.72**
Inpatient Utilization—General Hospital/Acute Care			
Maternity—Days/1,000 Member Years—10–19 Years	—	27.27	**28.03**
Maternity—Days/1,000 Member Years—20–44 Years	—	171.84	**149.64**
Maternity—Days/1,000 Member Years—45–64 Years	—	1.97	**1.85**
Maternity—Days/1,000 Member Years—Total	—	88.82	**82.50**
Maternity—Discharges/1,000 Member Years—10–19 Years	—	9.65	**9.72**
Maternity—Discharges/1,000 Member Years—20–44 Years	—	63.18	**54.81**
Maternity—Discharges/1,000 Member Years—45–64 Years	—	0.63	**0.56**
Maternity—Discharges/1,000 Member Years—Total	—	32.50	**30.03**

HEDIS Measure	MY 2022	MY 2023	SWA
Maternity—Average Length of Stay—10–19 Years	—	2.82	**2.88**
Maternity—Average Length of Stay—20–44 Years	—	2.72	**2.73**
Maternity—Average Length of Stay—45–64 Years	—	3.13	**3.29**
Maternity—Average Length of Stay—Total	—	2.73	**2.75**
Surgery—Days/1,000 Member Years—Less than 1 Year	—	616.39	**463.70**
Surgery—Days/1,000 Member Years—1–9 Years	—	39.42	**33.47**
Surgery—Days/1,000 Member Years—10–19 Years	—	36.85	**32.49**
Surgery—Days/1,000 Member Years—20–44 Years	—	110.61	**106.78**
Surgery—Days/1,000 Member Years—45–64 Years	—	379.07	**356.86**
Surgery—Days/1,000 Member Years—65–74 Years	—	288.59	**393.71**
Surgery—Days/1,000 Member Years—75–84 Years	—	651.36	**944.71**
Surgery—Days/1,000 Member Years—86 Years and Older	—	508.73	**584.92**
Surgery—Days/1,000 Member Years—Total	—	124.12	**123.56**
Surgery—Discharges/1,000 Member Years—Less than 1 Year	—	23.45	**19.95**
Surgery - Discharges/1,000 Member Years—1–9 Years	—	3.91	**3.54**
Surgery - Discharges/1,000 Member Years—10–19 Years	—	4.66	**4.35**
Surgery - Discharges/1,000 Member Years—20–44 Years	—	15.65	**14.26**
Surgery - Discharges/1,000 Member Years—45–64 Years	—	45.86	**42.97**
Surgery - Discharges/1,000 Member Years—65–74 Years	—	27.20	**42.16**
Surgery - Discharges/1,000 Member Years—75–84 Years	—	66.81	**87.74**
Surgery - Discharges/1,000 Member Years—85 Years and Older	—	59.85	**51.79**
Surgery - Discharges/1,000 Member Years—Total	—	14.23	**14.43**
Surgery—Average Length of Stay—Less than 1 Year	—	26.29	**23.24**
Surgery—Average Length of Stay—1–9 Years	—	10.08	**9.44**
Surgery—Average Length of Stay—10–19 Years	—	7.90	**7.46**
Surgery—Average Length of Stay—20–44 Years	—	7.07	**7.49**
Surgery—Average Length of Stay—45–64 Years	—	8.27	**8.31**
Surgery—Average Length of Stay—65–74 Years	—	10.61	**9.34**
Surgery—Average Length of Stay—75–84 Years	—	9.75	**10.77**
Surgery—Average Length of Stay—85 Years and Older	—	8.50	**11.29**
Surgery—Average Length of Stay—Total	—	8.72	**8.56**
Medicine—Days/1,000 Member Years—Less than 1 Year	—	399.89	**414.29**
Medicine—Days/1,000 Member Years—1–9 Years	—	46.78	**40.91**

HEDIS Measure	MY 2022	MY 2023	SWA
Medicine—Days/1,000 Member Years—10–19 Years	—	31.44	**27.72**
Medicine—Days/1,000 Member Years—20–44 Years	—	119.05	**108.57**
Medicine—Days/1,000 Member Years—45–64 Years	—	440.18	**393.48**
Medicine—Days/1,000 Member Years—65–74 Years	—	313.52	**550.81**
Medicine—Days/1,000 Member Years—75–84 Years	—	567.85	**921.88**
Medicine—Days/1,000 Member Years—85 Years and Older	—	389.03	**1,617.67**
Medicine—Days/1,000 Member Years—Total	—	129.83	**129.96**
Medicine—Discharges/1,000 Member Years—Less than 1 Year	—	82.28	**75.93**
Medicine—Discharges/1,000 Member Years—1–9 Years	—	13.50	**11.75**
Medicine—Discharges/1,000 Member Years—10–19 Years	—	9.11	**7.45**
Medicine—Discharges/1,000 Member Years—20–44 Years	—	26.84	**23.27**
Medicine—Discharges/1,000 Member Years—45–64 Years	—	85.85	**73.88**
Medicine—Discharges/1,000 Member Years—65–74 Years	—	58.17	**99.37**
Medicine—Discharges/1,000 Member Years—75–84 Years	—	108.56	**158.65**
Medicine—Discharges/1,000 Member Years—85 Years and Older	—	89.78	**164.51**
Medicine—Discharges/1,000 Member Years—Total	—	28.47	**26.76**
Medicine—Average Length of Stay—Less than 1 Year	—	4.86	**5.46**
Medicine—Average Length of Stay—1–9 Years	—	3.47	**3.48**
Medicine—Average Length of Stay—10–19 Years	—	3.45	**3.72**
Medicine—Average Length of Stay—20–44 Years	—	4.43	**4.67**
Medicine—Average Length of Stay—45–64 Years	—	5.13	**5.33**
Medicine—Average Length of Stay—65–74 Years	—	5.39	**5.54**
Medicine—Average Length of Stay—75–84 Years	—	5.23	**5.81**
Medicine—Average Length of Stay—85 Years and Older	—	4.33	**9.83**
Medicine—Average Length of Stay—Total	—	4.56	**4.86**
Total Inpatient—Days/1,000 Member Years—Less than 1 Year	—	1,016.28	**877.99**
Total Inpatient—Days/1,000 Member Years—1–9 Years	—	86.20	**74.37**
Total Inpatient—Days/1,000 Member Years—10–19 Years	—	95.55	**88.24**
Total Inpatient—Days/1,000 Member Years—20–44 Years	—	401.50	**364.98**
Total Inpatient—Days/1,000 Member Years—45–64 Years	—	821.22	**752.20**
Total Inpatient—Days/1,000 Member Years—65–74 Years	—	602.12	**944.52**
Total Inpatient—Days/1,000 Member Years—75–84 Years	—	1,219.21	**1,866.59**

HEDIS Measure	MY 2022	MY 2023	SWA
Total Inpatient—Days/1,000 Member Years—85 Years and Older	—	897.76	**2,202.59**
Total Inpatient—Days/1,000 Member Years—Total	—	318.35	**315.49**
Total Inpatient—Discharges/1,000 Member Years—Less than 1 Year	—	105.73	**95.88**
Total Inpatient—Discharges/1,000 Member Years—1–9 Years	—	17.41	**15.29**
Total Inpatient—Discharges/1,000 Member Years—10–19 Years	—	23.43	**21.53**
Total Inpatient—Discharges/1,000 Member Years—20–44 Years	—	105.67	**92.34**
Total Inpatient—Discharges/1,000 Member Years—45–64 Years	—	132.34	**117.41**
Total Inpatient—Discharges/1,000 Member Years—65–74 Years	—	85.37	**141.53**
Total Inpatient—Discharges/1,000 Member Years—75–84 Years	—	175.37	**246.39**
Total Inpatient—Discharges/1,000 Member Years—85 Years and Older	—	149.63	**216.30**
Total Inpatient—Discharges/1,000 Member Years—Total	—	66.27	**63.75**
Total Inpatient—Average Length of Stay—Less than 1 Year	—	9.61	**9.16**
Total Inpatient—Average Length of Stay—1–9 Years	—	4.95	**4.10**
Total Inpatient—Average Length of Stay—10–19 Years	—	4.08	**4.86**
Total Inpatient—Average Length of Stay—20–44 Years	—	3.80	**3.95**
Total Inpatient—Average Length of Stay—45–64 Years	—	6.21	**6.41**
Total Inpatient—Average Length of Stay—65–74 Years	—	7.05	**6.67**
Total Inpatient—Average Length of Stay—75–84 Years	—	6.95	**7.58**
Total Inpatient—Average Length of Stay—85 Years and Older	—	6.00	**10.18**
Total Inpatient—Average Length of Stay—Total	—	4.80	**4.95**
Enrollment by Product Line			
Less than 1 year	—	11,905	**39,430**
1–4 Years	—	48,863	**154,688**
5–9 Years	—	61,390	**194,614**
10–14 Years	—	60,025	**187,448**
15–17 Years	—	35,848	**113,890**
18–19 Years	—	20,567	**67,190**
20–24 Years	—	41,722	**144,726**
25–29 Years	—	30,569	**119,861**
30–34 Years	—	29,615	**117,909**
35–39 Years	—	25,187	**102,144**

HEDIS Measure	MY 2022	MY 2023	SWA
40–44 Years	—	22,294	**90,116**
45–49 Years	—	17,049	**68,991**
50–54 Years	—	14,789	**61,320**
55–59 Years	—	14,718	**60,505**
60–64 Years	—	13,907	**57,221**
65–69 Years	—	1,161	**3,396**
70–74 Years	—	170	**1,046**
75–79 Years	—	74	**592**
80–84 Years	—	48	**421**
85–89 Years	—	NA	**224**
90 Years and Older	—	NA	**173**
Unknown	—	NA	**NA**
Total	—	449,932	**1,585,904**
Language Diversity of Membership			
Spoken Language Preferred for Health Care—Health Plan	—	0.00%	**23.84%**
Spoken Language Preferred for Health Care—CMS/State	—	99.91%	**76.01%**
Spoken Language Preferred for Health Care—Other Third-Party	—	0.09%	**0.15%**
Preferred Language for Written Materials—Health Plan	—	0.00%	**23.78%**
Preferred Language for Written Materials—CMS/State	—	99.91%	**52.79%**
Preferred Language for Written Materials—Other Third-Party	—	0.09%	**23.43%**
Other Language Needs—Health Plan	—	0.00%	**19.20%**
Other Language Needs—CMS/State	—	99.91%	**47.96%**
Other Language Needs—Other Third-Party	—	0.09%	**32.83%**
Spoken Language Preferred for Health Care—Percent English	—	98.36%	**89.10%**
Spoken Language Preferred for Health Care—Percent Non-English	—	1.55%	**1.78%**
Spoken Language Preferred for Health Care—Percent Declined	—	0.00%	**0.00%**
Spoken Language Preferred for Health Care—Percent Unknown	—	0.09%	**9.12%**
Language Preferred for Written Materials—Percent English	—	98.36%	**66.23%**
Language Preferred for Written Materials—Percent Non-English	—	1.55%	**1.37%**
Language Preferred for Written Materials—Percent Declined	—	0.00%	**0.00%**
Language Preferred for Written Materials—Percent Unknown	—	0.09%	**32.40%**

HEDIS Measure	MY 2022	MY 2023	SWA
Other Language Needs—Percent English	—	98.36%	**47.18%**
Other Language Needs—Percent Non-English	—	1.55%	**0.80%**
Other Language Needs—Percent Declined	—	0.00%	**0.00%**
Other Language Needs—Percent Unknown	—	0.09%	**52.02%**
Race/Ethnicity Diversity of Membership			
Race—Health Plan	—	0.00%	**22.17%**
Race—CMS/State	—	88.86%	**56.65%**
Race—Other Direct	—	1.59%	**0.43%**
Race—Direct Total	—	90.44%	**79.25%**
Race—Indirect Total	—	0.00%	**0.61%**
Race—Unknown Total	—	9.56%	**20.14%**
Ethnicity—Health Plan	—	0.00%	**22.63%**
Ethnicity—CMS/State	—	2.16%	**35.49%**
Ethnicity—Other Direct	—	8.10%	**2.20%**
Ethnicity—Direct Total	—	10.26%	**60.32%**
Ethnicity—Indirect Total	—	26.82%	**8.74%**
Ethnicity—Unknown Total	—	62.92%	**30.93%**
Race: White—Ethnicity: Hispanic or Latino	—	1.05%	**0.81%**
Race: White—Ethnicity: Not Hispanic or Latino	—	14.83%	**28.15%**
Race: White—Ethnicity: Asked but No Answer	—	0.00%	**0.02%**
Race: White—Ethnicity: Unknown	—	21.57%	**7.88%**
Race: White—Ethnicity: Total	—	37.46%	**36.87%**
Race: Black or African American—Ethnicity: Hispanic or Latino	—	0.26%	**0.67%**
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	17.42%	**25.38%**
Race: Black or African American—Ethnicity: Asked but No Answer	—	0.00%	**0.03%**
Race: Black or African American—Ethnicity: Unknown	—	30.74%	**11.17%**
Race: Black or African American—Ethnicity: Total	—	48.41%	**37.26%**
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	0.04%	**0.03%**
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	0.24%	**0.48%**

HEDIS Measure	MY 2022	MY 2023	SWA
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	0.40%	**0.21%**
Race: American Indian or Alaska Native—Ethnicity: Total	—	0.68%	**0.72%**
Race: Asian—Ethnicity: Hispanic or Latino	—	0.02%	**0.04%**
Race: Asian—Ethnicity: Not Hispanic or Latino	—	0.47%	**1.58%**
Race: Asian—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Asian—Ethnicity: Unknown	—	0.86%	**1.02%**
Race: Asian—Ethnicity: Total	—	1.35%	**2.64%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	—	0.01%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	0.02%	**0.02%**
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	0.38%	**0.15%**
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	0.32%	**0.68%**
Race: Some Other Race—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Some Other Race—Ethnicity: Unknown	—	1.80%	**1.19%**
Race: Some Other Race—Ethnicity: Total	—	2.50%	**2.02%**
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	0.00%	**0.14%**
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	0.01%	**0.02%**
Race: Two or More Races—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Two or More Races—Ethnicity: Unknown	—	0.02%	**0.16%**
Race: Two or More Races—Ethnicity: Total	—	0.03%	**0.33%**
Race: Unknown—Ethnicity: Hispanic or Latino	—	0.62%	**0.83%**
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	1.43%	**7.38%**
Race: Unknown—Ethnicity: Asked but No Answer	—	0.00%	**2.65%**
Race: Unknown—Ethnicity: Unknown	—	7.51%	**9.27%**
Race: Unknown—Ethnicity: Total	—	9.56%	**20.14%**
Race: Total—Ethnicity: Hispanic or Latino	—	2.37%	**2.67%**

HEDIS Measure	MY 2022	MY 2023	SWA
Race: Total—Ethnicity: Not Hispanic or Latino	—	34.71%	**63.68%**
Race: Total—Ethnicity: Asked but No Answer	—	0.00%	**2.71%**
Race: Total—Ethnicity: Unknown	—	62.92%	**30.93%**
Race: Total—Ethnicity: Total	—	100.00%	**100.00%**
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Unknown	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Total	—	0.00%	**0.00%**

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

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

Measure Status	MY 2022	MY 2023
≥ NCQA National 50th Percentile Benchmark	28	190
< NCQA National 50th Percentile Benchmark	50	85
NCQA National Benchmark Unavailable	11	12
Total	89	287

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- LHCC's rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was above the NCQA national 50th percentile benchmark for MY 2023. Additionally, LHCC's rate on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for

MY 2023. These results suggest that LHCC was effective in ensuring that adult members on antipsychotics were screened for diabetes and had their diabetes monitored, resulting in positive health outcomes for this population. **[Quality]**

- LHCC's rate on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC was effective in ensuring that adult members with cardiovascular disease and schizophrenia who are on antipsychotics had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- LHCC's rate on the *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC was effective in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- LHCC's rates on the following *Childhood Immunization Status* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, and *Hepatitis A*. These results suggest that LHCC was effective in ensuring that children 2 years of age were receiving some immunizations to help protect them against a potential life-threatening disease. **[Quality and Access]**
- LHCC's rates on the following *Immunizations for Adolescents* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *Meningococcal*, *Tdap/TD*, *HPV*, *Combination 1*, and *Combination 2*. These results suggest that LHCC was effective in ensuring that that adolescent members were receiving immunizations to help protect them against meningococcal disease, tetanus, diphtheria, pertussis, and HPV. **[Quality]**
- LHCC's rate on the *Colorectal Cancer Screening* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC was effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- LHCC's rate on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- LHCC's rates on the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* and *Statin Adherence 80%—Total* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC effectively coordinated with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) received statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- LHCC's rates on the *HbA1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC effectively coordinated with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- LHCC's rate on the *Eye Exam for Patients With Diabetes* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC effectively coordinated

with providers to ensure that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

- LHCC's rate on the *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC effectively coordinated with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- LHCC's rates on the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* and *Engagement of SUD Treatment* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC effectively coordinated with providers to initiate treatment for members with a new SUD episode and engaged these members in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment. **[Quality, Timeliness, and Access]**
- LHCC's rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC effectively coordinated with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- LHCC's rate on the *Cervical Cancer Screening* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC effectively coordinated with providers to ensure that women ages 21 to 64 years received appropriate, early detection cancer screening. **[Quality]**
- LHCC's rates on the following *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *5–11 Years*, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*. These results suggest that LHCC effectively coordinated with providers to help members with persistent asthma manage this treatable condition. **[Quality]**
- LHCC's rates on the following *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *20–44 Years*, *45–64 Years*, *65 Years and Older*, and *Total*. These results suggest that LHCC effectively coordinated with PCPs to ensure that adult members were engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- LHCC's rates on the *Well-Child Visits in the First 30 Months of Life—First 15 Months* and *15 Months–30 Months* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC effectively coordinated with PCPs to ensure that children were seen within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**
- LHCC's rates on the *Child and Adolescent Well-Care Visits—12–17 Years*, *18–21 Years*, and *Total* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC effectively coordinated with providers to ensure that adolescent members received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For LHCC, the following opportunities for improvement were identified:

- LHCC's rates on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC has room for improvement in its coordination with providers to ensure that members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. **[Quality, Timeliness, and Access]**
- LHCC's rates on the *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. Additionally, LHCC's rates on the *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC has room for improvement with properly managing the care of patients discharged after an emergency department (ED) visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**
- LHCC's rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- LHCC's rates on the following *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *Blood Glucose Testing*, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*. These results suggest that LHCC has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- LHCC's rates on the following *Childhood Immunization Status* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *DTaP*, *Pneumococcal Conjugate*, *Rotavirus*, *Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*. These results suggest that LHCC has room for improvement in coordinating with providers to ensure children under 2 years of age are receiving all appropriate vaccinations to protect them against potential life-threatening diseases. **[Quality and Access]**
- LHCC's rates on the following *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *BMI Percentile Documentation*, *Counseling for Nutrition*, and *Counseling for Physical Activity*. These results suggest that LHCC has room for improvement in coordinating with providers to ensure that child and adolescent members are having their weight and BMI monitored, and are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- LHCC's rate on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement in

coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**

- LHCC's rate on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- LHCC's rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder are dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- LHCC's rates on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC has room for improvement in coordinating with providers to initiate appropriate follow-up visits for children prescribed ADHD medication. **[Quality, Timeliness, and Access]**
- LHCC's rates on the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC has room for improvement in coordinating with providers to treat adult members diagnosed with major depression with antidepressant medication and help members remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**
- LHCC's rate on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement with ensuring that a diagnosis of upper respiratory infection (URI) does not result in an antibiotic dispensing event for members. **[Quality]**
- LHCC's rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- LHCC's rate on the *Use of Imaging Studies for Low Back Pain* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- LHCC's rate on the *Non-Recommended Cervical Screening in Adolescent Females* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that LHCC has room for improvement with ensuring that providers avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- LHCC's rates on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that LHCC has room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care, in alignment with guidance

provided by the AAP and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**

For LHCC, the following recommendations were identified:

- To improve performance on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, and *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators, HSAG recommends that LHCC work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and LHCC. LHCC could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**
- To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommends that LHCC work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators, HSAG recommends that LHCC work with providers to identify root causes and trial interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**
- To improve performance on the *Childhood Immunization Status* measure indicators, HSAG recommends that LHCC focus its efforts on increasing immunizations for children. LHCC should also consider conducting a root cause analysis and implementing appropriate interventions to improve performance that are evidence-based and address barriers such as parent dissatisfaction, provider capacity, or appointment accessibility. Additionally, LHCC should consider inclusion of parent/guardian and provider participation when evaluating root causes of measure performance. **[Quality and Access]**
- To improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, HSAG recommends that LHCC work with PCPs to identify and address barriers to primary care visits for children and adolescents in need of weight assessment and education on healthy habits. LHCC could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality]**
- To improve performance on the *Controlling High Blood Pressure* measure, HSAG recommends that LHCC work with providers to identify and address barriers to effective blood pressure management in members. LHCC could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood

pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, LHCC could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**

- To improve performance on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure, HSAG recommends that LHCC work with providers to identify and address barriers to effective blood pressure management for diabetic members. HSAG also recommends that LHCC expand on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. LHCC could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that LHCC work with providers to identify and address barriers to the dispensing of antipsychotic medications to members with schizophrenia or schizoaffective disorder, and barriers to adherence to antipsychotic medications. LHCC could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as provider education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator, HSAG recommends that LHCC work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. LHCC could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality, Timeliness, and Access]**
- To improve performance on the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators, HSAG recommends that LHCC work with providers to identify and address barriers to prescribing antidepressant medication to adult members with major depression and helping members remain on antidepressant medication for the appropriate amount of time. LHCC could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient education and offering telehealth services. **[Quality]**
- To improve performance on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, HSAG recommends that LHCC work with providers to trial solutions to reduce antibiotic dispensing to treat URI. LHCC could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**

- To improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, HSAG recommends that LHCC work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. LHCC could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that LHCC focus its efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that LHCC work with providers to trial solutions to reduce the inappropriate ordering of imaging studies. Appropriate interventions to improve performance may include addressing provider behaviors, provider incentives, and addressing member expectation with education. **[Quality]**
- To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommends that LHCC work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- To improve performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, HSAG recommends that LHCC work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. HSAG recommends that LHCC consider implementing interventions such as offering provider education and engagement opportunities, including educational webinars and newsletters on prenatal and postpartum health services, and piloting a member incentives program designed to encourage engagement in timely prenatal and postpartum care services. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

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

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

Technical Methods of Data Collection

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

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

HEDIS Measure Validation

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

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

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

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

Non-HEDIS Measure Validation

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

How Conclusions Were Drawn

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

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

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

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

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

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

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

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

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

Standard Name	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Enrollment and Disenrollment[2]		**85.7%[2]**	
Member Rights and Confidentiality	99.1%		
Member Information			
Coverage and Authorization of Services	99.2%		
Emergency and Post-Stabilization Services			
Availability of Services	100%		
Assurances of Adequate Capacity and Services	100%		
Coordination and Continuity of Care	91.0%		
Provider Selection	100%		
Subcontractual Relationships and Delegation	100%		
Practice Guidelines	100%		
Health Information Systems	100%		
Quality Assessment and Performance Improvement Program	100%		
Grievance and Appeal Systems	100%		
Program Integrity	94.6%		

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

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

Follow-Up on Previous Compliance Review Findings

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

LHCC achieved compliance in three of three elements from the 2023 CAPs, demonstrating positive improvements in implementing CAPs from 2023.

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

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

For LHCC, the following opportunities for improvement were identified:

- HSAG did not identify any opportunities for improvement.

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

- HSAG did not identify any required actions or recommendations.

Methodology

Standards

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

Table 4-2—Summary of CR Standards

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

NA=not applicable for the PAHPs

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

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

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

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

Objectives

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

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

Technical Methods of Data Collection

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

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

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

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

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

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

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

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

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

Results

Provider Directory Accuracy

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

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

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

Specialty Type	Response Rate		Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**420**	**84.0%**	**361**	**86.0%**	**364**	**86.7%**	**317**	**75.5%**	**304**	**72.4%**	**284**	**67.6%**	**338**	**80.5%**
Internal Medicine/ Family Medicine	85	85.0%	75	88.2%	75	88.2%	59	69.4%	55	64.7%	49	57.6%	67	78.8%
Pediatrics	95	95.0%	92	96.8%	86	90.5%	81	85.3%	81	85.3%	78	82.1%	82	86.3%
OB/GYN	81	81.0%	62	76.5%	69	85.2%	56	69.1%	61	75.3%	57	70.4%	64	79.0%
Specialists (any)	91	91.0%	76	83.5%	81	89.0%	75	82.4%	62	68.1%	58	63.7%	76	83.5%
Behavioral Health (any)	68	68.0%	56	82.4%	53	77.9%	46	67.6%	45	66.2%	42	61.8%	49	72.1%

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

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

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**500**	**211**	**50.0%**
Internal Medicine/Family Medicine	100	35	42.7%
Pediatrics	100	69	73.0%

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
OB/GYN	100	37	50.0%
Specialists (any)	100	45	52.0%
Behavioral Health (any)	100	25	32.3%

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

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

Table 5-3—Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**289**	**57.8%**
Total reasons for noncompliance[1]	**332**	**NA**
Provider does not participate with MCO or Louisiana Medicaid	80	16.0%
Provider is not at site	40	8.0%
Provider not accepting new patients	26	5.2%
Wrong telephone number	2	0.4%
No response/busy signal/disconnected telephone number (after three calls)	78	15.6%
Representative does not know	0	0.0%
Incorrect address reported	43	8.6%
Address (suite number) needs to be updated	16	3.2%
Wrong specialty reported	47	9.4%

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

Provider Access Surveys

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

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

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

Specialty Type	Response Rate		Correct Address		Offered Requested Services		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients		Provider at Location	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**127**	**63.5%**	**92**	**72.4%**	**48**	**37.8%**	**38**	**29.9%**	**36**	**28.3%**	**34**	**26.8%**	**23**	**18.1%**
Primary Care	35	58.3%	26	74.3%	15	42.9%	11	31.4%	10	28.6%	9	25.7%	4	11.4%
Pediatrics	32	80.0%	27	84.4%	18	56.3%	16	50.0%	15	46.9%	14	43.8%	12	37.5%
OB/GYNs	12	60.0%	9	75.0%	5	41.7%	4	33.3%	4	33.3%	4	33.3%	3	25.0%
Endocrinologists	12	60.0%	8	66.7%	4	33.3%	4	33.3%	4	33.3%	4	33.3%	4	33.3%
Dermatologists	8	40.0%	5	62.5%	3	37.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Neurologists	14	70.0%	9	64.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Orthopedic Surgeons	14	70.0%	8	57.1%	3	21.4%	3	21.4%	3	21.4%	3	21.4%	0	0.0%

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

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

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Routine Primary Care Visit	36	66.7%
Routine Pediatric Visit	2	100%
Non-Urgent Sick Primary Care Visit	1	100%
Non-Urgent Sick Pediatric Visit	6	25.0%
OB/GYN Visit	14	100%
Endocrinologist Visit	105	0.0%

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Dermatologist Visit	NA	NA
Neurologist Visit	NA	NA
Orthopedic Surgeon Visit	NA	NA

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

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

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

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**200**	**22**	**31.2%**
Primary Care	60	4	23.9%
Pediatrics	40	11	45.0%
OB/GYNs	20	3	33.3%
Endocrinologists	20	4	40.0%
Dermatologists	20	0	11.7%
Neurologists	20	0	38.3%
Orthopedic Surgeons	20	0	26.7%

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

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

Table 5-7—Provider Access Survey Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**178**	**89.0%**
Total reasons for noncompliance[1]	**178**	**NA**
Provider does not participate with MCO or Louisiana Medicaid	12	6.0%
Provider is not at site	11	5.5%
Provider not accepting new patients	2	1.0%
Wrong telephone number	10	5.0%

Reason	Count	Rate (%)
No response/busy signal/disconnected telephone number (after three calls)	65	32.5%
Incorrect address reported	35	17.5%
Address (suite number) needs to be updated	1	0.5%
Wrong specialty reported	42	21.0%

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

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

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

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**50**	**9**	**21.3%**
Primary Care	15	3	20.0%
Pediatrics	10	3	30.0%
OB/GYNs	5	1	20.0%
Endocrinologists	5	0	6.7%
Dermatologists	5	1	20.0%
Neurologists	5	0	13.3%
Orthopedic Surgeons	5	1	33.3%

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

NAV Audit

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

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

Table 5-9 contains the percentage of members LHCC reported with access at the statewide level, by provider type and by urbanicity. LDH established a 100 percent threshold for MCOs when determining

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

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

Provider Type	Urbanicity	Percentage of Members With Access
Adult PCP (Family/General Practice; Internal Medicine and Physician Extenders*)	Urban	99.7%
	Rural	100%
Pediatrics (Family/General Practice; Internal Medicine and Physician Extenders*)	Urban	99.5%
	Rural	100%
Federally Qualified Health Centers (FQHCs)	Urban	86.4%
	Rural	99.6%
Rural Health Clinics (RHCs)	Urban	55.9%
	Rural	100%
Acute Inpatient Hospitals	Urban	84.4%
	Rural	99.8%
Laboratory	Urban	99.9%
	Rural	99.8%
Radiology	Urban	99.7%
	Rural	99.8%
Pharmacy	Urban	97.6%
	Rural	100%
Hemodialysis Centers	Urban	99.5%
	Rural	100%
Home Health	Urban	NA
	Rural	NA
OB/GYNs (access only for adult female members)	Urban	95.4%
	Rural	91.3%
Allergy/Immunology	Urban	99.9%
	Rural	97.5%
Cardiology	Urban	99.9%
	Rural	99.9%

Provider Type	Urbanicity	Percentage of Members With Access
Dermatology	Urban	90.6%
	Rural	90.5%
Endocrinology and Metabolism (Adult)	Urban	99.9%
	Rural	99.9%
Endocrinology and Metabolism (Pediatric)	Urban	99.8%
	Rural	99.8%
Gastroenterology	Urban	99.9%
	Rural	99.9%
Hematology/Oncology	Urban	99.9%
	Rural	99.6%
Nephrology	Urban	99.9%
	Rural	99.9%
Neurology (Adult)	Urban	99.9%
	Rural	99.6%
Neurology (Pediatric)	Urban	NA
	Rural	NA
Ophthalmology	Urban	99.9%
	Rural	99.9%
Orthopedics (Adult)	Urban	99.9%
	Rural	99.9%
Orthopedics (Pediatric)	Urban	99.9%
	Rural	99.9%
Otorhinolaryngology/Otolaryngology	Urban	99.9%
	Rural	99.9%
Urology	Urban	99.9%
	Rural	99.8%
Other Specialty Care	Urban	99.9%
	Rural	100%
Psychiatrists	Urban	96.9%
	Rural	99.9%
Physicians and Licensed Mental Health Professionals (LMHPs) who specialize in pregnancy-related and postpartum	Urban	99.9%
	Rural	97.6%

Provider Type	Urbanicity	Percentage of Members With Access
depression or related mental health disorders		
Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD	Urban	99.9%
	Rural	94.4%
Behavioral Health Specialist (Other Specialty Care: Advance Practice Register Nurse [APRN-BH] specialty, Licensed Psychologist or Licensed Clinical Social Worker [LCSW])	Urban	91.4%
	Rural	96.6%
PRTFs, PRTF (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21)	Urban	100%
	Rural	NA
American Society of Addiction Medicine (ASAM) Level 1	Urban	90.7%
	Rural	96.6%
ASAM Level 2.1	Urban	89.8%
	Rural	92.1%
ASAM Level 2 WM	Urban	76.9%
	Rural	62.0%
ASAM Level 3.1 (Adult over age 21)	Urban	93.6%
	Rural	32.8%
ASAM Level 3.1 (Pediatric under age 21)	Urban	98.5%
	Rural	NA
ASAM Level 3.2 WM (Adult over age 21)	Urban	91.2%
	Rural	71.9%
ASAM Level 3.2 WM (Pediatric under age 21)	Urban	87.6%
	Rural	NA
ASAM Level 3.3 (Adult over age 21)	Urban	88.0%
	Rural	52.9%
ASAM Level 3.5 (Adult over age 21)	Urban	94.4%
	Rural	64.7%
ASAM Level 3.5 (Pediatric under age 21)	Urban	99.3%
	Rural	NA
ASAM Level 3.7 (Adult over age 21)	Urban	91.9%
	Rural	92.8%
ASAM Level 3.7 WM	Urban	99.9%
	Rural	96.7%

Provider Type	Urbanicity	Percentage of Members With Access
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	100%
	Rural	100%
Mental Health Rehabilitation Agency (Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention—Mental Health Rehabilitation Agency [Legacy MHR], Behavioral Health Rehab Provider Agency [Non-Legacy MHR]; Mental Health Clinics)	Urban	91.4%
	Rural	96.6%

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

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

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

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

Provider Type	Indicator
Internal Medicine (that agree to full PCP responsibility)	
FQHCs	
RHCs	
Pediatric PCP Physician Extenders (Equivalent to 0.5 PCP FTE)	Pediatric PCP Physician Extenders (FTEs) (1:1,000 members equivalent to 0.5 PCP FTE)
Nurse practitioners (that agree to full PCP responsibility)	
Certified nurse mid-wives (that agree to full PCP responsibility)	
Physician assistants linked to a physician group (that agree to full PCP responsibility)	
Statewide Combined Ratio	
Combined Adult PCP FTEs (1:1,000 adult members)	1.22%
Combined Pediatrics (1:1,000 adult members)	1.62%

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

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

Specialty Care	Indicator	Statewide Ratio
OB/GYN	1:10,000 (0.01%)	0.14%
Allergy/Immunology	1:100,000 (0.001%)	0.01%
Cardiology	1:20,000 (0.005%)	0.10%
Dermatology	1:40,000 (0.003%)	0.03%
Endocrinology and Metabolism	1:25,000 (0.004%)	0.02%
Gastroenterology	1:30,000 (0.003%)	0.05%
Hematology/Oncology	1:80,000 (0.001%)	0.05%
Nephrology	1:50,000 (0.002%)	0.04%
Neurology	1:35,000 (0.003%)	0.07%
Ophthalmology	1:20,000 (0.005%)	0.04%

Specialty Care	Indicator	Statewide Ratio
Orthopedics	1:15,000 (0.007%)	0.07%
Otorhinolaryngology/Otolaryngology	1:30,000 (0.003%)	0.05%
Urology	1:30,000 (0.003%)	0.03%

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

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

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	99%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	99%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	99%

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

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

Type of Visit/Admission/Appointment	Access/Timeliness Standard
Urgent Non-Emergency Care	24 hours, 7 days/week within 24 hours of request
Non-Urgent Sick Primary Care	72 hours
Non-Urgent Routine Primary Care	6 weeks
After Hours, by Phone	Answer by live person or call back from a designated medical practitioner within 30 minutes
OB/GYN Care for Pregnant Women	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High-Risk Pregnancy, Any Trimester	3 days
Family Planning Appointments	1 week
Specialist Appointments	1 month

Type of Visit/Admission/Appointment	Access/Timeliness Standard
Scheduled Appointments	Less than a 45-minute wait in office
Psychiatric Inpatient Hospital (Emergency Involuntary)	4 hours
Psychiatric Inpatient Hospital (Involuntary)	24 hours
Psychiatric Inpatient Hospital (Voluntary)	24 hours
ASAM Levels 3.3, 3.5, and 3.7	10 business days
Residential WM	24 hours when medically necessary
PRTF	20 calendar days

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- To increase the overall accuracy of the health plan's directory data, LHCC performed provider outreach "CMS" mock audits to verify demographic data. A sample of highly utilized CMS specialties were randomly pulled, providers were called to verify demographic data, audit results were summarized, and deficiencies were addressed. **[Quality, Timeliness, and Access]**
- By subcontracting with Veda, LHCC's subcontractor used to validate provider data, provider data accuracy results have steadily improved since implementation in June 2023. Veda, LHCC's subcontractor used to validate provider data, has shown provider data accuracy results have steadily improved since implementation in June 2023. **[Quality, Timeliness, and Access]**
- No strengths were identified in the PDV activity, as all indicators had match rates below 90 percent.
- Of the cases that offered an appointment date in the provider access survey, 100 percent of routine pediatric, non-urgent sick primary care, and OB/GYN cases offered an appointment within the compliance standard. **[Timeliness and Access]**

For LHCC, the following opportunities for improvement were identified:

- No specific opportunities were identified related to the systems, management processes, or data integration LHCC had in place to inform network adequacy standard and indicator calculation and reporting. **[Quality, Timeliness, and Access]**
- Acceptance of Louisiana Medicaid was inaccurate with 67.6 percent of providers in the PDV and 28.3 percent of locations in the provider access survey accepting Louisiana Medicaid. **[Quality and Access]**
- Acceptance of LHCC was inaccurate with 72.4 percent of providers in the PDV and 29.9 percent of locations in the provider access survey accepting LHCC. **[Quality and Access]**
- Overall, only 75.5 percent of providers in the PDV and 37.8 percent of locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**

- Overall, acceptance of new patients was relatively low with 80.5 percent of providers in the PDV and 26.8 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 86.7 percent of PDV locations and 18.1 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Of the cases that offered an appointment, 66.7 percent of routine primary care cases, 25.0 percent of non-urgent sick pediatric visits, and 0.0 percent of endocrinologist cases were within the wait time compliance standards. Additionally, dermatologist, neurologist, and orthopedic surgeon cases did not offer any new patient appointment dates. **[Timeliness and Access]**
- Compliance scores varied by survey type with an overall compliance score of 50.0 percent for the PDV, 31.2 percent for the provider access survey, and 21.3 percent for the after-hours provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with behavioral health having the lowest compliance score at 32.3 percent and pediatrics having the highest compliance score at 73.0 percent for the PDV. For the provider access survey, dermatologists exhibited the lowest compliance score at 11.7 percent and pediatrics exhibited the highest compliance score at 45.0 percent. While endocrinologists exhibited the lowest compliance score at 6.7 percent, orthopedic surgeons exhibited the highest compliance score at 33.3 percent for the after-hours provider access survey. **[Quality and Access]**

For LHCC, the following recommendations were identified:

- LDH should provide LHCC with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which LHCC will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). **[Quality and Access]**
- In addition to updating provider information, LHCC should conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent. **[Quality and Access]**

  LHCC should consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care. **[Timeliness and Access]**

Methodology

Objectives

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

The objectives of the validation of network adequacy are to:

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

Technical Methods of Data Collection

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

Provider Directory Validation

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

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

Provider Access Survey

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

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

NAV Audit

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

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

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

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

Provider Directory Validation

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

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

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

HSAG used the following validation responses to assess each indicator:

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

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

Table 5-14—Noncompliance Reasons and Weighting

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

Table 5-15—Weighted Noncompliance Criteria

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

Weighted compliance score equation:

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

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

Provider Access Survey

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

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

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

Table 5-16—Noncompliance Reasons and Weighting

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

Table 5-17—Weighted Noncompliance Criteria

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

Weighted compliance score equation:

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

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

NAV Audit

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

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

How Conclusions Were Drawn

Provider Directory Validation/Provider Access Survey

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

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

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

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

NAV Audit

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

Table 5-19—Validation Score Calculation

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

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

Table 5-20—Indicator-Level Validation Rating Categories

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

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

- Requesting that the MCO provide a root cause analysis of the finding.
- Working with the MCE to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:

– The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

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

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

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

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

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

Results

LHCC submitted its adult CAHPS data according to NCQA protocol. However, due to an administrative oversight, LHCC did not upload these data to IDSS. HSAG utilized the adult CAHPS data provided by LHCC to perform analysis of this activity.

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

Table 6-1—Adult Achievement Scores

Measure	2022	2023	2024
Rating of Health Plan	77.94%	77.08%	78.67%
Rating of All Health Care	NA	71.43%	80.65%
Rating of Personal Doctor	84.07%	83.25%	89.33% ↑
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	NA	75.06%	84.25% ▲
Getting Care Quickly	NA	85.07%	83.35%
How Well Doctors Communicate	NA	92.80%	93.78%
Customer Service	NA	NA	NA

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

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 NCQA national average.*

↓ *Indicates the 2024 score is statistically significantly lower than the 2024 NCQA national average.*

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

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

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

Table 6-2—General Child Achievement Scores

Measure	2022	2023	2024
Rating of Health Plan	86.78%	86.26%	90.40%
Rating of All Health Care	NA	87.69%	89.26%
Rating of Personal Doctor	87.39%	89.38%	91.08%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	NA	NA	NA
Getting Care Quickly	NA	NA	NA

Measure	2022	2023	2024
How Well Doctors Communicate	NA	95.21%	93.18%
Customer Service	NA	NA	NA

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

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- For the adult population, LHCC's score for *Getting Needed Care* was statistically significantly higher in 2024 than 2023. **[Quality and Access]**
- For the adult population, LHCC's score for *Rating of Personal Doctor* was statistically significantly higher than the 2024 NCQA national average. **[Quality]**
- For the general child population, LHCC's scores were not statistically significantly higher in 2024 than 2023 nor statistically significantly higher than the 2024 NCQA national averages on any of the measures; therefore, no strengths were identified.

For LHCC, the following opportunities for improvement were identified:

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

For LHCC, the following recommendation was identified:

- HSAG recommends that LHCC focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, and providing awareness to members and providers during the survey period. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

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

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

How Conclusions Were Drawn

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

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

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

7. Behavioral Health Member Satisfaction Survey

Results

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

Table 7-1—Adult Achievement Scores for LHCC

Measure	2023	2024	Healthy Louisiana SWA
Rating of Health Plan	55.65%	60.00%	56.43%
How Well People Communicate	91.35%	90.43%	92.65%
Cultural Competency	66.67%+	83.33%+	82.85%+
Helped by Counseling or Treatment	68.55%	71.81%	69.38%
Treatment or Counseling Convenience	86.29%	87.25%	88.46%
Getting Needed Treatment	81.97%	83.22%	81.83%
Help Finding Counseling or Treatment	37.50%+	57.14%+	52.90%
Customer Service	64.29%+	72.41%+	71.32%
Helped by Crisis Response Services	85.71%+	69.23%+	75.17%

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

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

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

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

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

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

Table 7-2—Child Achievement Scores for LHCC

Measure	2023	2024	Healthy Louisiana SWA
Rating of Health Plan	70.37%+	62.07%+	65.18%
How Well People Communicate	96.29%+	94.94%+	90.74%
Cultural Competency	100.00%+	100.00%+	90.17%+
Helped by Counseling or Treatment	68.52%+	50.85%+	56.92%
Treatment or Counseling Convenience	92.45%+	91.53%+	86.12%
Getting Needed Treatment	84.91%+	74.58%+	77.13%
Help Finding Counseling or Treatment	66.67%+	50.00%+	46.93%+
Customer Service	60.00%+	63.64%+	59.54%+

Measure	2023	2024	Healthy Louisiana SWA
Getting Professional Help	90.57%+	86.44%+	85.72%
Help to Manage Condition	94.23%+	93.10%+	83.70%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
↑ *Indicates the 2024 score is statistically significantly higher than the 2024 Healthy Louisiana SWA.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 Healthy Louisiana SWA.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*
— *Indicates the MCO's score was not reported due to insufficient data.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- For the adult and child populations, LHCC's scores were not statistically significantly higher than the 2024 Healthy Louisiana SWA nor statistically significantly higher in 2024 than 2023 on any of the measures; therefore, no strengths were identified.

For LHCC, the following opportunities for improvement were identified:

- For the adult and child populations, LHCC's scores were not statistically significantly lower than the 2024 Healthy Louisiana SWA nor statistically significantly lower in 2024 than 2023 on any of the measures; therefore, no opportunities for improvement were identified.

For LHCC, the following recommendations were identified:

- HSAG recommends that LHCC focus on increasing response rates to the behavioral health member satisfaction survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of the survey, using customer service techniques, oversampling, and providing awareness to members and providers during the survey period. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

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

How Conclusions Were Drawn

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

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

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

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

8. Health Disparities Focus Study

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

Methodology

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

Technical Methods of Data Collection

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

Description of Data Obtained

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

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

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

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

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

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

How Data Were Aggregated and Analyzed

Statewide Rate Calculations

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

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

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

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

Table 8-2—Transformed Rate Calculation

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

Identifying Health Disparities

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

Table 8-3—Race Categories

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

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

Table 8-4—Ethnicity Categories

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

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

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

Table 8-5—Geography Categories and Parishes

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

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

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

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

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

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

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

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

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

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

Disparities were categorized by the following color system:

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

How Conclusions Were Drawn

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

[8-1] Please refer to those measure indicators in Table 8-1 marked with an asterisk (*) for measure indicators for which a lower rate indicates better performance.

[8-2] Quality Compass® is a registered trademark of the NCQA.

[8-3] Data. Medicaid.gov. 2022 Child and Adult Health Care Quality Measures. Available at: https://data.medicaid.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6. Accessed on: Dec 17, 2024.

9. Case Management Performance Evaluation

Introduction

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

Activities Conducted During SFY 2024

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

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

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

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

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

For LHCC, the following opportunities for improvement were identified:

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

For LHCC, the following recommendations were identified:

- The health plan would benefit from strengthening documentation of an enrollee's refusal of in-person contact for completion of reassessments, plan of care updates, and scheduled contacts. **[Quality and Timeliness]**
- The health plan should evaluate its unable to reach process to ensure alignment with LDH's expectations for outreach. **[Quality and Timeliness]**
- The health plan should evaluate its multidisciplinary care team (MCT) process to ensure MCT meetings are conducted at regular intervals, or that an enrollee's refusal of MCT meetings is documented. The health plan could consider evaluating its documentation templates to identify opportunities to reduce duplication of case manager efforts. The health plan should ensure that, during initial and ongoing enrollee engagement, the enrollee is informed of the purpose of the MCT and options for conducting the MCT meetings. **[Timeliness]**
- The health plan should evaluate its oversight processes to ensure that case managers and supervisory staff have tools to effectively manage activities that occur regularly. Case management system flags, queues, or reports that remind staff members of upcoming contact requirements should be considered; leadership audits may need to focus on these time-sensitive elements. **Quality, Timeliness]**

Methodology

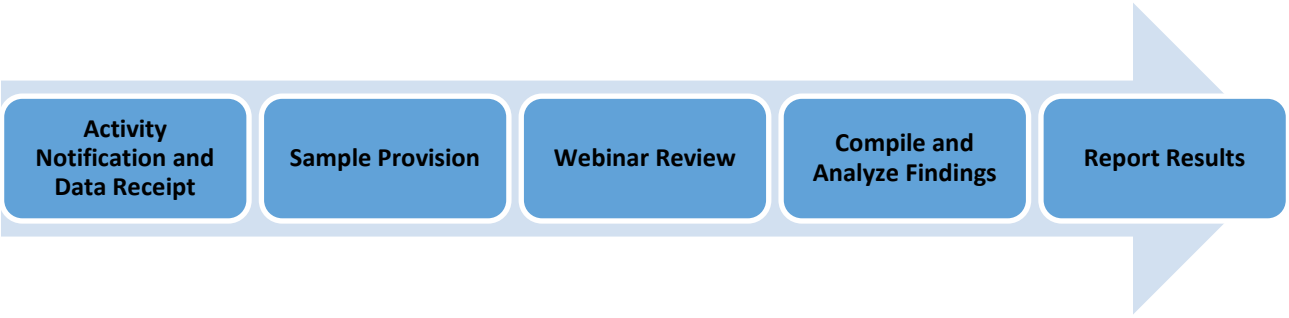
Objectives

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

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

Review Process

HSAG's case management review process included five activities:



Activity 1: Activity Notification and Data Receipt

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

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

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

Activity 2: Sample Provision

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

For the CY 2023 review:

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

For the CY 2024 review:

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

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

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

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

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

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

Table 9-2—Activity 2: Sample Provision

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

Activity 3: Webinar Review

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

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

The webinar review consisted of several key activities:

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

Table 9-3—Activity 3: Webinar Review

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

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

Scoring Methodology

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

Met indicated full compliance defined as the following:

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

Not Met indicated noncompliance defined as either of the following:

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

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

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

Reporting of Abuse, Neglect, or Exploitation (ANE)

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

Activity 4: Compile and Analyze Findings

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

Domain and Element Performance

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

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

Analysis of findings included identification of opportunities for improvement.

Activity 5: Report Results

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

How Conclusions Were Drawn

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

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

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

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

10. Quality Rating System

Results

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

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

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

**This rating includes all measures in the 2024 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*
NC indicates that the plan received a rating of 0 for the measure in this composite.

LHCC received an Overall Rating of 3.5 points, with 4.0 points for the Consumer Satisfaction composite, 2.5 points for the Prevention and Equity composite, and 3.0 points for the Treatment composite.

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- For the Consumer Satisfaction composite, LHCC received 5.0, 4.0, and 3.5 points for the Satisfaction with Plan Physicians, Satisfaction with Plan Services, and Getting Care subcomposites, respectively. These subcomposites are based on LHCC member responses to CAHPS survey questions, demonstrating LHCC members are satisfied with their health plan and providers, and get the care they need. **[Quality and Timeliness]**
- For the Treatment composite, LHCC received 4.0 points for the Diabetes subcomposite, demonstrating strength for LHCC related to diabetic care. **[Quality and Access]**

For LHCC, the following opportunities for improvement were identified:

- For the Prevention and Equity composite, LHCC received 2.0 points for the Children and Adolescent Well-Care subcomposite, demonstrating opportunities for improvement for LHCC related to ensuring children and adolescents receive important immunizations, and have their BMI percentiles documented. Additionally, LHCC received 0.0 points (i.e., as indicated by "NC" in the report card) for the Equity subcomposite, demonstrating opportunities for improvement for LHCC related to collecting race and ethnicity information from its members. **[Quality and Access]**
- For the Treatment composite, LHCC received 2.0 points for the Reduce Low Value Care subcomposite, demonstrating opportunities for LHCC to ensure members with low back pain do not receive unnecessary imaging tests. LHCC also received 1.0 point for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for LHCC to ensure timely follow-up after hospitalizations and ED visits for mental illness. **[Quality, Timeliness, and Access]**

For LHCC, the following recommendation was identified:

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

Methodology

Objectives

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

Technical Methods of Data Collection

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

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

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

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

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

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

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

Table 10-2—Measure Rate Scoring Descriptions

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

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

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

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

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

Table 10-3—Scoring Rounding Rules

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

How Conclusions Were Drawn

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

11. MCO Strengths, Opportunities for Improvement, and Recommendations

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

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

Overall MCO Strengths	
Quality, Timeliness, and Access	• For the NAV audit, HSAG assessed LHCC's results for statewide provider-to-member ratios by provider type and determined that LHCC's statewide results met or exceeded LDH-established requirements. • HSAG assessed LHCC's results for behavioral health providers to determine the accessibility and availability of appointments and determined that LHCC met all LDH-established performance goals for three reported appointment access standards. • The 2024 Health Plan Report Card shows that, for the Overall Rating, LHCC received 3.5 stars. LHCC received 5.0 stars for the Satisfaction with Plan Physicians subcomposite and 4.0 stars for the Satisfaction with Plan Services and Diabetes subcomposites, demonstrating strength for LHCC in these areas. • LHCC demonstrated strength by developing and carrying out methodologically sound designs and interventions for all five PIPs. • For one PIP, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years,* LHCC's reported results demonstrated statistically significant improvement from baseline to the most recent remeasurement for all performance indicators. • LHCC demonstrated strength in compliance by achieving compliance in all three elements from the 2023 CAPs.

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

Overall MCO Opportunities for Improvement	
Quality, Timeliness, and Access	• The 2024 Health Plan Report Card showed that LHCC received 2.0 stars for the Children and Adolescent Well-Care and Reduce Low Value Care subcomposites as well as 1.0 star for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for improvement for LHCC in these areas.
Quality and Access	• LHCC demonstrated opportunities to improve the provider information that it maintains and provides.

Table 11-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
To facilitate significant outcomes improvement for all PIPs, HSAG recommends that LHCC review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. LHCC should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed through new or revised interventions to drive outcomes improvement.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities Goal 8: Minimize wasteful spending
HSAG recommends that LHCC focus on increasing response rates to the CAHPS survey and behavioral health member satisfaction survey for all populations so there are greater than 100 respondents for each measure.	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
HSAG recommends that LHCC evaluate performance measures with rates below the NCQA national 50th percentile.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 5: Improve chronic disease management and control Goal 6: Partner with communities to improve population health and address health disparities Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
HSAG recommends that LDH provide LHCC with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which LHCC will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance).	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care

Overall MCO Recommendations	
HSAG recommends that LHCC conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
HSAG recommends that LHCC consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care.	Goal 1: Ensure access to care to meet enrollee needs

12. Follow-Up on Prior Year's Recommendations

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

EQRO's Scoring Assessment

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

High indicates *all* of the following:

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

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

Medium indicates one or more of the following:

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

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

Low indicates one or more the following:

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

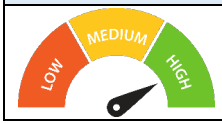
A rating of *low* is indicated by the following graphic: 

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

Recommendations
None identified.

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

1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
LHCC should conduct a root cause analysis for the Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Mental Illness, and Follow-Up After Emergency Department Visit for Substance Use measures and implement appropriate interventions to improve performance, such as providing patient and provider education and enhancing communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
Response
Describe initiatives implemented based on recommendations: Root cause analysis is performed annually in collaboration with our state Process Improvement Projects (PIP) initiatives. As a result of this analysis, the following initiatives were implemented: • Strategic provider partnerships to expand availability of follow up care and access to BH services (i.e. Upward Health, One Telemed) • Supplemental text/email outreach following discharge to support member communication preferences. • Ongoing collaboration to expand Admission, Discharge, and Transfer (ADT) feed connectivity with BH providers/facilities to supplement BH Inpatient prior authorizations and support discharge notifications. • Education with BH facilities and emergency departments to encourage participation in ADT/Health Information Exchange applications.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Although thresholds for NCQA 50th percentile were not met for behavioral follow up care measures, the following trends were observed: • Rates for follow-up after hospitalization and emergency department (ED) visits for mental illness showed improvement: • FUH (7d) rate 20.70%, a 1.96% improvement over prior year

1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
• FUH (30d) rate 41.60%, a 2.12% improvement over prior year • FUA (7d) rate 13.42%, a 2.46% decline over prior year *NCQA spec changes • FUA (30d) rate 21.89%, a 4.16% decline over prior year *NCQA spec changes • FUM (30d) rate 38.24%, a 0.48% improvement over prior year • The following rates for follow-up after emergency department visits for substance use and mental illness declined year over year: • FUA (7d) rate 13.42%, a 2.46% decline over prior year *NCQA spec changes • FUA (30d) rate 21.89%, a 4.16% decline over prior year *NCQA spec changes • FUM (7d) rate 22.39%, a 0.15% decline over prior year **NCQA HEDIS® Technical Specifications for MY2023 included changes to the eligible population resulting in challenges when comparing year-over-year rates.*
Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions include: • Provider community abrasion, perceived inadequate reimbursements via LA Medicaid fee schedule, challenges with timely notification of IP/ED visits related to ADT participation &/or EHR connectivity, limited provider staffing resources, and documentation/coding practices impeding identification of BH Inpatient (IP)/ED visits and follow-up needs. • Challenges with successful member engagement/outreach to promote education, support engagement and compliance with health care appointments and follow up care. • Impacts of member Social Determinants of Care, including inconsistent access to telephone services, stable home environment/member relocations without updating demographics, and transportation needs.
Identify strategy for continued improvement or overcoming identified barriers: • Expansion of a provider partnership offering multi-disciplinary home-based care. • Provider partnership with telehealth provider piloting a "live transfer"/ "on-demand" model. • Continued provider education/outreach to encourage participation in ADT platforms and improve awareness of ED/IP discharge portal reports, ADT feeds, resources, and available incentives. • IT enhancements to expand ADT identification of BH IP visits. • Ongoing multi-modal member outreach to provide follow-up reminders, assist with appointment scheduling, and provide resources/support following IP/ED visits. • Specialized TOC team to provide complex discharge assistance. • Work with Assertive Community Treatment (ACT) teams to develop/improve collaborative relationships with BH IP facilities. • Addition of member incentive in 2025 for completion of BH follow-up visits.
HSAG Assessment

Recommendations
LHCC should convene a focus group to conduct root cause analyses to determine barriers to child and adolescent members accessing preventive care. The focus group should include parent/guardian and provider participation as well as subject matter experts. The focus group should recommend evidenced-based interventions that address barriers. LHCC should consider holistic and novel interventions that aim to increase

Recommendations
preventive care rates rather than reiterating previous interventions focused on specific topics or short-term campaigns.
Response
Describe initiatives implemented based on recommendations: LHCC solicited member and provider feedback during Member Advisory Council meetings, Member Appreciation meetings, Community Health Advisory Program meetings, member grievance calls, and member & provider outreach. Initiatives implemented in response to the feedback include: • Expanded year-round digital member outreach campaign targeting child and adolescent preventive measures. • Provider Webinar hosted on 08/28/24 with a peer-led discussion by Dr. Keisha Harvey Mansfield/Family Medicine on evidenced based immunization recommendations. • Community events focused on member awareness and education regarding preventive care, assistance for overcoming barriers to accessing preventive care, and available incentives for receiving preventive care.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): LHCC met thresholds for NCQA 50th percentile in 2023, with significant improvements noted year over year in the following HEDIS measures associated with preventive care for child and adolescent members: • WCV (Total) rate 54.23%, a 5.11% increase over prior year • W30 (1st-14 months) rate 63.17%, a 4.60% increase over prior year • W30 (15- 30 months) rate 70.49%, a 7.08% increase over prior year • WCC (BMI) rate 81.51%, a 20.93% increase over prior year • WCC (Counseling for Nutrition) 70.56%, a 13.38% increase over prior year • IMA (Combo2) rate 38.87%, a 1.60% increase over prior year Although thresholds for NCQA 50th percentile were not met in 2023 for WCC (Counseling for Physical Activity) and CIS (Combo 3), significant improvement was noted year over year: • WCC (Counseling for Physical Activity) 59.12%, a 7.54 increase over prior year • CIS (Combo 3) rate 63.8%, a 2.00% increase over prior year
Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions include: • Challenges with successful member engagement/outreach to promote education, support engagement and compliance with health care appointments and follow up care. • Parental vaccine hesitancy contributing to low levels of vaccine coverage with a higher degree of hesitancy with the influenza vaccine compared to other routine childhood vaccines. • Provider documentation/coding practices and reported limited staffing resources
Identify strategy for continued improvement or overcoming identified barriers: • Expand provider incentives to include BMI & SDOH assessments. • Expand member incentives to include Child Flu Vaccination
HSAG Assessment

Recommendations
LHCC should focus its efforts on increasing metabolic testing for children and adolescents with ongoing antipsychotic medication use and on increased use of first-line psychosocial interventions for children and

Recommendations
adolescents on antipsychotics. LHCC should consider conducting a root cause analysis for the Metabolic Monitoring for Children and Adolescents on Antipsychotics and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measures and implementing appropriate interventions to improve performance.
Response
Describe initiatives implemented based on recommendations: Root cause analysis indicated opportunity for enhanced provider education and support to ensure proper care and treatment of members receiving or potentially needing antipsychotic medications. Initiatives implemented include: • Provider outreach/education focusing on available resources, coding/documenting, & in-office/Point of Care lab testing. • Increased year-round abstraction/record reviews. • Increasing EHR connectivity to improve capture of electronic measures including Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E). • Updating toolkits and clinical practice guidelines to ensure providers have access to up to date evidenced based resources.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): For MY23, the NCQA 50th percentile was met for APP, with improvement noted year over year: • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) rate 61.74%, a 1.64% improvement over prior year. Although the threshold for NCQA 50th percentile was not met for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), slight improvement was noted year over year: • Metabolic testing for children and adolescents with ongoing antipsychotic medication use (APM-E) rate 24.86%, a 0.13% improvement over prior year.
Identify any barriers to implementing initiatives: • Limited provider IT resources for expanding or enhancing EHR systems. • Limited EHR interoperability to adequately capture electronic performance measures.
Identify strategy for continued improvement or overcoming identified barriers: • Expand EHR connectivity and continued provider education/support.
HSAG Assessment

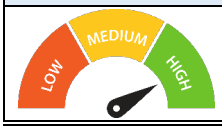
Recommendations
LHCC should focus its efforts on increasing timely prenatal and postpartum care for members. LHCC should also consider conducting a root cause analysis for the Prenatal and Postpartum Care measure and implementing appropriate interventions to improve performance, such as outreach campaigns, patient and provider education, and member incentives.
Response
Describe initiatives implemented based on recommendations: • Education/collaboration with OB providers on appointment availability standards and proper coding. • Increased face to face interaction with members at plan-sponsored baby showers and other community events.

Recommendations
• Updated member-facing pregnancy program materials highlighting the importance of prenatal and postpartum care. • Launched a post-partum outreach pilot with maternal-child health community health workers. • Conducted OB Care Manager training focused on educating members on available pregnancy/postpartum incentives.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Although thresholds for NCQA 50th percentile were not met for Prenatal and Postpartum Care, the following trends were noted year over year:
• Prenatal and Postpartum Care:
  • Timeliness of Prenatal Care rate 78.83%, a 2.68% decrease over prior year
  • Postpartum Care rate 77.62%, a 2.44% improvement over prior year

Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions include: • Timely notification of pregnancy (NOP). • Challenges with successful member engagement/outreach to promote education and support compliance with health care appointments and follow up care.
Identify strategy for continued improvement or overcoming identified barriers: • Multimodal member outreach to increase member awareness of resources, incentives, appointment scheduling assistance, and importance of prenatal/postpartum care. • Expansion of post-partum outreach pilot with community health workers.
HSAG Assessment

Recommendations
Require the MCOs to conduct a root cause analysis for measures associated with members with schizophrenia and implement appropriate interventions to improve performance.
Response
Describe initiatives implemented based on recommendations: Root cause analysis indicated opportunity for enhanced provider education and support to ensure proper care and treatment of members with schizophrenia, including necessary cardiovascular and diabetes screenings/monitoring. Initiatives implemented include: • Targeted face to face outreach to low performing providers to assist with education, member gaps, tips for compliance, and proper coding guidelines. • Targeted mailers/provider letters offering education/awareness for identified noncompliant prescribing practices and/or follow up care for members receiving antipsychotic medications.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): LHCC met thresholds for NCQA 50th percentile in 2023, with improvements noted year over year in the following HEDIS measures associated with members with schizophrenia: • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) rate 81.91%, a 5.07% increase over prior year (met 75th) • Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) rate 73.32%, a 5.88% increase over prior year (met 66.67th)

Recommendations
• Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD), rate 83.89%, a 1.37% increase over prior year (met 75th) Although thresholds for NCQA 50th percentile were not met in 2023 for Adherence to Antipsychotic Medications for Individuals with Schizophrenia, improvement was noted year over year: • Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) rate 60.69%, a 1.55% increase over prior year
Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions included: • Challenges with successful member engagement/outreach to promote education, support engagement/compliance with health care appointments and follow up care. • Providers also report staffing resources as a barrier to following up with members to ensure completion of required screenings and medication compliance.
Identify strategy for continued improvement or overcoming identified barriers: • Addition of this population as a priority focus in the Population Health Management (PHM) BH Workgroup to develop new interventions to improve performance measures associated with members with schizophrenia.
HSAG Assessment

Recommendations
Require the MCOs to conduct a root cause analysis to determine why members are not receiving appropriate treatment of respiratory conditions and implement appropriate interventions to improve performance.
Response
Describe initiatives implemented based on recommendations: • LHCC adopted respiratory treatment/antibiotic stewardship measures as priorities in our 2024 Low Value Care Strategy, incorporating provider education and targeted performance reviews and outreach to lower performing providers to offer resources and best practice guidance. • Provider webinar was hosted on 09/25/24 with a peer-led discussion by Dr. John Vanchiere/Pediatrics on best practices and clinical guidelines for antibiotic prescribing. • Antibiotic Stewardship provider collaterals were developed and distributed electronically.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Although thresholds for NCQA 50th percentile were not met for members receiving appropriate treatment of respiratory conditions, a slight improvement was noted year over year in the following performance measure: • Appropriate Treatment for Upper Respiratory Infection (URI) rate 80.12%, 0.17% improvement over prior year; (URI measure retired by NCQA for 2024) The rate for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) declined year over year: • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis rate 51.12%, a 1.46% decrease from prior year

Recommendations
Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions include: • Retrospective performance measures pose a challenge to address proactively, vs member-targeted open 'care gap' approach. • Prescribing practices may be influenced by members' insistence on antibiotics or 'definitive care' vs over the counter or symptom relief recommendations; limited health literacy surrounding risks related to antibiotic resistance.
Identify strategy for continued improvement or overcoming identified barriers: • Continue implementation of Low Value Care Strategy with focused on provider education and outreach to low performing providers. • Follow performance of new related HEDIS measure Antibiotic Treatment for Respiratory Conditions (AXR).
HSAG Assessment

Recommendations
Require the MCOs to focus efforts on decreasing unnecessary imaging and screenings. The MCOs should conduct a root cause analysis and implement appropriate interventions to decrease unnecessary imaging for low back pain and unnecessary screenings for cervical cancer among adolescent females.
Response
Describe initiatives implemented based on recommendations: A root cause analysis was conducted to identify and address the underlying causes of unnecessary imaging and screenings. It was noted that the Non-Recommended Cervical Cancer Screening (NCS) HEDIS performance measure was retired for 2024 by NCQA, citing data revealed little room for improvement. Proposed interventions for unnecessary imaging for SFY 2025 include: • Collaborate with Medical Directors & and 3rd party vendor medical reviewers managing non-emergent outpatient radiology testing authorizations) on peer reviews, outlier trends, and any quality-of-care concerns. • Provider education on evidenced based recommendations and available clinical practice guidelines for diagnosis and treatment of low back pain.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Thresholds for NCQA 50th percentile were not met for the following unnecessary imaging and screening measures: • Use of Imaging Studies for Low Back Pain (LBP) rate 69.11%, a 2.36% decline over prior year • Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) rate 2.05%, a 0.02% improvement over prior year (NCS measure retired by NCQA in 2024)
Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions include: • Retrospective performance measures pose a challenge to address proactively, vs member-targeted open 'care gap' approach.

Recommendations
• Prescribing practices may be influenced by members' insistence on diagnostic testing; limited health literacy surrounding risks related to unnecessary radiation exposure.
Identify strategy for continued improvement or overcoming identified barriers: • Collaborate with Medical Directors and 3rdparty vendor medical reviewers on peer reviews/QOC referrals and identification of outlier trends. • Provide education to providers and members via mailer, email outreach, and plan website on evidenced based recommendations for low back pain.
HSAG Assessment

Recommendations
Require the MCOs to focus efforts on increasing timely follow-up care, following discharge, for members who access the hospital and ED for mental illness or substance abuse. The MCOs should conduct a root cause analysis and implement appropriate interventions to improve performance.
Response
Describe initiatives implemented based on recommendations: Root cause analysis is performed annually in collaboration with our state PIP initiatives. As a result of this analysis, the following initiatives were implemented: • Strategic provider partnerships to expand availability of follow up care and access to BH services (i.e. Upward Health, One Telemed) • Supplemental text/email outreach following discharge to support member communication preferences. • Ongoing collaboration to expand ADT connectivity with BH providers/facilities to supplement BH Inpatient prior authorizations and support discharge notifications. • Education with BH facilities and emergency department to encourage participation in ADT/Health Information Exchange applications.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Although thresholds for NCQA 50th percentile were not met for behavioral follow up care measures, the following trends were observed:
• Rates for follow-up after hospitalization and emergency department visits for mental illness showed improvement:
  • FUH (7d) rate 20.70%, a 1.96% improvement over prior year
  • FUH (30d) rate 41.60%, a 2.12% improvement over prior year
  • FUA (7d) rate 13.42%, a 2.46% decline over prior year *NCQA spec changes
  • FUA (30d) rate 21.89%, a 4.16% decline over prior year *NCQA spec changes
  • FUM (30d) rate 38.24%, a 0.48% improvement over prior year
 	
The following rates for follow-up after emergency department visits for substance use and mental illness declined year over year:
  • FUA (7d) rate 13.42%, a 2.46% decline over prior year *NCQA spec changes
  • FUA (30d) rate 21.89%, a 4.16% decline over prior year *NCQA spec changes
  • FUM (7d) rate 22.39%, a 0.15% decline over prior year
**NCQA HEDIS® Technical Specifications for MY2023 included changes to the eligible population resulting in challenges when comparing year-over-year MY2022 rates.*

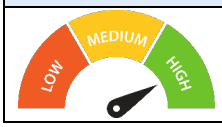
Recommendations
Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions include: • Provider community abrasion, perceived inadequate reimbursements via LA Medicaid fee schedule, challenges with timely notification of IP/ED visits related to ADT participation, limited provider staffing resources, and documentation/coding practices impeding identification of BH IP/ED visits and follow-up needs. • Challenges with successful member engagement/outreach to promote education, support engagement and compliance with health care appointments and follow up care. • Impacts of member Social Determinants of Care, including inconsistent access to telephone services, stable home environment. and transportation needs.
Identify strategy for continued improvement or overcoming identified barriers: • Expansion of provider partnership offering multi-disciplinary home-based care. • Partnership with telehealth provider piloting a "live transfer"/ "on-demand" model. • Continued provider education/outreach to encourage participation in ADT platforms and improve awareness of ED/IP discharge portal reports, ADT feeds, resources, and available incentives. • IT enhancements to expand ADT identification of BH IP visits. • Ongoing multi-modal member outreach to provide follow-up reminders, assist with appointment scheduling, and provide resources/support following IP/ED visits. • Specialized TOC team to provide complex discharge assistance.   • Work with ACT teams to develop/improve collaborative relationships with BH IP facilities. • Addition of member incentives in 2025 for completion of BH follow-up visits.
HSAG Assessment


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

2. Prior Year Recommendations from the EQR Technical Report for Compliance Review:
Require the MCOs to review and update, as appropriate, policies, procedures, manuals, and handbooks to consistently include all member for cause and without cause reasons for disenrollment.
Response
Describe initiatives implemented based on recommendations: LHCC updated our *LA.ELIG.02 Disenrollment* policy immediately following the virtual Compliance Review. This item was not included in the Compliance Review Final Report as a corrective action, per HSAG on 12/6/2023. There were no additional actions required of LHCC.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: N/A

2. Prior Year Recommendations from the EQR Technical Report for Compliance Review:
HSAG Assessment


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

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
To improve access to care, LHCC should adopt a programmatic approach to identify barriers to access across all aspects of Medicaid operations. A planwide taskforce should include provider network staff members, subject matter experts for the access-related HEDIS measures that performed poorly, utilization management staff members, and other members as determined by LHCC. The taskforce should include key community stakeholders to identify barriers/facilitators to members accessing preventive and follow-up care. LHCC should consider multi-tiered approaches such as: • Reviewing provider office procedures for ensuring appointment availability standards. • Conducting "secret shopper" provider office surveys. • Evaluating member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. • Conduct drill-down analyses of access-related measures to determine disparities by race, ethnicity, age group, geographic location, etc.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) has implemented a structured and multi-tiered approach to address barriers to care and improve access for Medicaid members. This approach aligns with the recommendation for a comprehensive programmatic strategy involving data-driven processes and cross-functional collaboration. Key initiatives currently in place include: 1. **Multitiered Data Collection and Analysis**: LHCC employs a robust data collection system across various departments and uses it to monitor and improve access to care. This data is reviewed in health plan quality meetings, ensuring a coordinated approach across teams. 2. **CAHPS Survey Utilization**: We leverage CAHPS survey results to gauge member satisfaction with access to care. Specifically, we monitor: • The percentage of members who reported timely access to routine and urgent care. • Member satisfaction regarding access to specialists. 3. **Member Complaints and Grievances Review**: We analyze member complaints and grievances related to access issues on a regular basis and share findings through multiple reporting platforms. This allows us to identify recurring barriers in real-time and implement targeted solutions. 4. **Provider Site-Specific Surveys and Audits**: Random access audits are conducted for PCP and behavioral services, high-volume specialists (OB/GYN), and high-impact specialists (Oncology) using

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
a standardized audit tool. This data is further analyzed across Louisiana to pinpoint disparities and address region-specific access issues. 5. **Provider Engagement and Education**: LHCC has strengthened provider engagement by incorporating appointment access education in new provider orientations and ongoing engagements. We also provide a comprehensive handout detailing access standards to ensure that all providers understand and meet access expectations. 6. **Telehealth Education for Providers and Members** LHCC does not currently have ongoing evaluation data on telehealth practices or member usage. Instead, LHCC focuses on educating both providers and members about telehealth opportunities, noting that not all visits are suitable for telehealth services. LHCC ensures that providers are well-informed about telehealth services through comprehensive training during New Provider Orientations and routine in-person visits. Providers are guided to consult the LHCC and Louisiana Department of Health (LDH) provider manuals, as well as the fee schedule, to confirm that their telehealth services align with state guidelines. Updates to telehealth guidelines from LDH are promptly communicated through an emailed provider newsletter and online postings. Additionally, LHCC has designated provider representatives throughout the state who are available for ad-hoc educational support as needed. To increase telehealth awareness and usage among our members, LHCC also conducts ongoing education through various communication channels, including member health blogs, email outreach, and the member handbook. This helps ensure both providers and members are informed about the availability, benefits, and guidelines associated with telehealth services, thereby improving access to care across the state. 7. **Drill-down Analyses of Access-Related Performance Measures.** We review several outcome data sources stratified by various demographics such as REL and geographic locations to inform initiatives and outreach strategies, leveraging key provider partnerships for targeted intervention as areas for focused opportunity are identified.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Overall improvement in many HEDIS measures indicative of improved access to care was noted in the other response sections for measures such as Child and Adolescent Well- Care Visits & Immunizations (W30, WCV, IMA, CIS), Screenings for Members with Schizophrenia (SMC, SMD, &SSD), and Postpartum Care (PPC). Additional HEDIS measures associated with access to care also noted significant improvements year over year and met NCQA 50th percentiles thresholds such as: • Cervical Cancer Screenings rate 58.64 %, a 1.95 % increase over prior year • Colorectal Cancer Screening rate 44.28 %, a 10.22 % increase over prior year • Adults Access to Preventive Services rate 79.11 %, a 4.42 % increase over prior year • Breast Cancer Screening rate 63.18%, a 7.44 % increase over prior year
Identify any barriers to implementing initiatives: Provider shortages across Louisiana significantly hinder the ability to meet access standards, with over half of Louisiana's parishes designated as Health Professional Shortage Areas. In many of these areas, there are simply not enough providers to meet required distance standards, which directly impacts the availability of nearby providers, who are often heavily booked. High turnover within provider groups further compounds this issue, as new staff members particularly front-line receptionists are frequently unaware of standards for after-hours

3. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
appointment availability. While office managers may understand these requirements, a lack of training for new staff handling calls has led to delays. Challenges also exist with successful member engagement/outreach to promote education, support engagement/compliance with health care appointments and follow up care.
Identify strategy for continued improvement or overcoming identified barriers: 1. **Provider Engagement and Resource Distribution:** • **Conduct Regular In-Person Visits:** Continue conducting proactive, face-to-face visits with providers to strengthen communication and address access standards. • **Distribute Reference Materials on Standards:** Provide easily accessible reference materials that outline standards and scheduling protocols, ensuring these are available at workstations within provider offices for quick staff reference. 2. **Telehealth Expansion Support:** • **Encourage and Assist with Telehealth Implementation:** Support providers in adopting telehealth services where applicable, particularly in areas with provider shortages, to offer patients more flexible access. • **Educate Providers and Members on Telehealth Benefits:** Inform both providers and members about the types of care needs telehealth can effectively meet when in-person appointments are limited, helping to expand utilization where appropriate. 3. **Incentives for Extended Hours:** • **Provide Incentives for Extended Operating Hours:** Continue offering incentives to providers willing to extend their hours, aiming to reduce the impact of high patient volumes and improve after-hours availability for members. 4. **Member Outreach and Feedback:** • **Member Outreach:** Multimodal outreach to increase member awareness of resources, incentives, appointment scheduling assistance, and importance preventive and follow-up care. • **Member Feedback:** Continued analysis from a variety of sources such as member surveys, grievances, member advisory sessions, etc. to identify barriers to members accessing preventive and follow-up care.
HSAG Assessment

Recommendations
To increase accuracy of online provider directories: • Provide each MCO with the case-level PDV data files and a defined timeline by which each plan will address provider data deficiencies. • Require the MCOs to conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
Response
Describe initiatives implemented based on recommendations: • HSAG has paused the provider data audits they facilitate for the 2024 year. When audit activities resume, LHCC will comply to the fullest extent with all requirements and recommendations/follow-up actions given by HSAG to address provider data deficiencies.

Recommendations
• LHCC has implemented several changes to the quarterly PDV (Provider Directory Validation) review work process.   • LHCC has enhanced our existing work process by which we review all data mismatches for PDV study indicators that scored below 90%. In this process we identify all practitioners in the study indicator that fell below 90%. Research into the mismatch is conducted to confirm if there is a discrepancy in our system data, contracting data, or other. Additionally, outbound calls are also made to the practitioner to confirm the discrepancy and, if applicable, what the correct data should be. Depending on our findings, further root cause analysis is conducted to determine why provider data is not accurate. Once the review is completed the assigned business analyst will provide a summary analysis of the findings to the PDM manager. Actions are taken accordingly based on the summary analysis.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A as all quarterly provider directory audits were paused for 2024 due to the LDH Network Adequacy Validation Project.
Identify any barriers to implementing initiatives: Quarterly provider directory audits were paused for 2024 due to the LDH Network Adequacy Validation Project. We expect these to resume in 2025.
Identify strategy for continued improvement or overcoming identified barriers: In addition to the changes made to LHCC's quarterly provider directory review work process, LHCC has implemented the use of several key reports. The review of these reports will allow LHCC to be more proactive in identify discrepancies in the provider data before they become an issue.
HSAG Assessment

Recommendations
To improve compliance with GeoAccess standards: • Require the MCOs to contract with additional providers, if available. • Encourage strategies for expanding the provider network such as enhanced reimbursement or expanding licensing to add additional ASAM LOCs. • Require the MCOs to conduct an in-depth review of provider types for which GeoAccess standards were not met to determine cause for failure and evaluate the extent to which the MCO has requested exemptions from LDH for provider types for which providers may not be available or willing to contract. • Require the MCOs to evaluate whether offering additional telehealth services could increase compliance with GeoAccess standards.
Response
Describe initiatives implemented based on recommendations: • LHCC conducted online searches using tools such as Healthgrades, Psychology Today, Health Standards and Web MD to identify providers to fill gaps in the network. • LHCC compared our network to our competitor's network especially those with other lines of business using their online FAP tools to identify potential recruitment opportunities. • Monitored out-of-network utilization for potential targets.

Recommendations
• Specific to ASAM LOC's: LHCC's Behavioral Health Medical Director, Sr. Vice President of Network, and Sr. Director of Network development held conference calls with substance use residential treatment providers in our network. The main topics included: barriers to providing care, current levels of care provided, adolescent female services, expanding levels of care/populations served, and opportunities to open new locations.   • ASAM providers have expressed limited interest to expand services in the shortage areas identified. The main barriers continue to be low fee schedule reimbursement and the concern that there is not enough volume to support expansion.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There has been minimal change, the providers needed to fill the gaps do not exist. • LHCC along with the other MCOs partnered with LDH on a Network Adequacy Validation Project. The purpose of the project was to validate provider demographics and appointment availability. The project completed last month. LHCC will revisit the possibility of using telemedicine to fill gaps.
Identify any barriers to implementing initiatives: • Provider shortage areas across Louisiana present the most significant challenge: more than 90% of Louisiana's parishes are designated as geographic health professional shortage areas. In many of these parishes, the providers needed to meet distance standards simply do not exist. • Providers have expressed limited interest to expand services in the shortage areas identified. The main barriers continue to be low fee schedule reimbursement and the concern that there is not enough volume to support expansion. • LHCC offered enhanced rates to expand current services and foundational payments to open new locations. Several of the providers expressed an interest but did not think there would be enough volume.
Identify strategy for continued improvement or overcoming identified barriers: • LHCC will continue to monitor competitor's websites, search online tools, and monitor out of network utilization to identify contracting opportunities to fill gaps. LHCC will continue to contract with available providers. • LHCC has not had any access issues, nor have we executed any single case agreements due to a network gap.
HSAG Assessment


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

Recommendations
None identified.

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

4. Prior Year Recommendations from the EQR Technical Report for the Behavioral Health Member Satisfaction Survey:
Require the MCOs to implement strategies to increase response rates to the behavioral health member satisfaction survey.
Response
Describe initiatives implemented based on recommendations: LHCC implemented a multi-disciplinary BH Member Experience Improvement Plan that includes initiatives to improve response rates for the Behavioral Health Member Satisfaction Survey such as: • Education provided to all MCO staff to increase knowledge surrounding member experience surveys. • Reoccurring communication to MCO staff on survey awareness and ways to improve member experience. • Notification to providers regarding education on BH Member Experience Surveys available in provider education portal. • Multimodal communication to members requesting their feedback/satisfaction via member survey completions.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LHCC does not yet have latest response rates from 2024 BH member survey fielded by LDH/HSAG
Identify any barriers to implementing initiatives: Barriers to implementation and impact of interventions include: • Challenges with survey return rates, successful member engagement related to potential survey fatigue.
Identify strategy for continued improvement or overcoming identified barriers: • Member facing MCO staff to remind members during survey fielding period to complete the 2025 BH Member Survey and solicit feedback on any barriers related to survey completion. • Collaborate with HSAG on survey methodology regarding member reminders during survey fielding (i.e., member follow up/reminders via phone and email) and potential change in survey identification selection in order to increase sample size.
HSAG Assessment


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

Recommendations
None identified.

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

Recommendations
None identified.

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

Recommendations
None identified.

Appendix A. MCO Health Equity Plan Summary

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

Health Equity Plan

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

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

Development and Implementation of Focus Areas

Overview

LHCC (Louisiana HealthCare Connections) has kicked off the year steadfast in our efforts to sustain progress made in year one towards equitable care for the members we serve. With this continued growth and progress, there have been some noted barriers and challenges along the way. Some of these challenges have impacted performance in quarters one and two, but proper remediation plans are in place to avoid these issues by year's end (December 2024). With a year of efforts to reflect upon, the themes of this year's health equity approach are "fidelity" and "leveraging." Our focus continues to be on process evaluation of existing programs, services, and internal application of our health equity efforts. Summarized within are our efforts and achievements to date. These initiatives underscore our commitment to advancing health equity and supporting the holistic well-being of our enrollees, particularly those facing significant health disparities.

Focus Area (A): Training

A1.1 Health Equity Training to all LHCC Staff – Building on the momentum of year one, LHCC has maintained significant strides towards our objectives in educating our staff on the implications of health disparities among vulnerable populations. In the first two quarters of 2024, we continued to broaden our Health Equity training initiatives, introducing Health Literacy and Health Equity training for legacy employees. This supplements the mandatory completion of the training for all newly hired staff, in addition to updates made to the Centene hosted Cultural Competency training as well as updated Social Determinants of Health training. Specific changes to the SDOH (Social Drivers of Health) training include highlighting updated definitions of determinants vs. drivers and understanding how those differences play a role in the overall member experience. We surpassed our 2023 goal of 95% completion by December 2023 and continue to remain on track for 2024. Notably, 75% of newly onboarded employees and 93% of legacy staff completed the training in the third quarter, positioning us well to continue meeting our target of 95% completion by December 2023, as outlined in Tables A1 and A2 for further training specifics. Furthermore, we continue to offer an expanded set of trainings to LHCC providers, delving into the complexities of Cultural Competency and trauma-informed care within the clinical setting, facilitated by our internal Centene Institute, as detailed in Table A3. A good portion of our 2024 yearly training courses is scheduled to be rolled out in quarters 3 and 4.

A1.2 Cultural Responsiveness and Implicit Bias Training – As previously communicated, LHCC introduced annual cultural responsiveness and implicit bias training for both LHCC staff and Network Providers. In 2024 we plan to maintain the previously established methods of implementation, having identified two intervention opportunities: during provider re-credentialing and annual compliance training. These training sessions are hosted through our Centene University platform as well as through our unique partnership with Trusted Provider Network (TPN). For LHCC Staff – we are confident that we will maintain our progress of achieving 95% participation among eligible staff and providers by December 2024. For detailed training records from January to May 2024, please refer to tables A1 and A2.

Through the MCO collaborative partnership with TPN, we continue to streamline training content and reporting, reducing completion attestation burdens for providers across multiple MCOs through a "no wrong door" approach. In 2024, the MCO's formed a roundtable to discuss modifications in approach and marketing of the "Advancing Wellness Together" training course to our provider networks. Meeting monthly, we review collective best practices, provider feedback, barriers to implementation and identify next steps. In addition to utilizing our medical directors as health equity Champions to share the importance and availability of the

Cultural Competency Trainings. Since the start of the partnership, LHCC has had 126 providers voluntarily register to complete the training. Figure A1 provides a breakdown of module offerings and statistics. To kick off Q3, the MCO's will be sending out a collaborative letter to providers and hospital networks to further inform them of the partnership while offering onsite coordination for in-person events as well as on-demand. To accommodate in person live sessions, the group agreed to a shorter introductory module to increase provider buy-in and engagement up front. Also, via the TPN dashboard, we see that 89 providers will soon require license renewals, and we will use this list to outreach for training completion.

A1.3 Childhood Adversity and Trauma – As previously highlighted, our strategy of conducting annual training for existing staff and providing onboarding sessions for new hires has resulted in the comprehensive training of most of our frontline staff on the critical aspects of Trauma-Informed Care. This includes understanding the profound effects of adverse childhood experiences on enrollees' interactions with the healthcare system. Detailed breakdowns of completed training from Q1 through Q2 of 2024 can be found in tables A1 and A2. Additionally, we are consistently enhancing our offerings by providing expanded Childhood Adversity and Trauma training sessions for providers through Centene University, as outlined in Table A2. We continue to outreach state resource programs to better understand additional opportunities for our Case management and Community Health Workers to receive full ACE certification. Additionally, through our Equitable Partnerships in Healthcare program, we have begun to think creatively about how to engage with community partners that serve as a resource for children exposed to childhood adversities and trauma. In doing so, we have formed a partnership with the ELZE Elite School of Performing Arts Summer Camp where mental health and holistic care of children occurs through their passion for the arts. At least 45% of camp attendees are Medicaid recipients. Starting this summer (June 2024) LHCC is sponsoring one student and bringing resources for families/promoting screenings at the end of summer performance. Additionally, we have developed a partnership with Southern University with two goals in mind: a) serve as premier sponsors of *Jags on the Bluff Day* – a day centered around youth and the importance of physical health; and b) to provide scholarships and opportunities for nursing students to gain community-based experiences throughout Louisiana. The Jags on the Bluff Day had over 200 attendees and proved to be a terrific opportunity to connect with the families we serve and the community.

Focus Area (B): Social Determinants of Health

B1.1 Community Resource List – Over the past year and a half, we have achieved significant strides in operationalizing the LHCC-curated FindHelp portal. We have enhanced its functionality to allow separate assessment of its usage by the public and by our staff, enabling us to evaluate the impact of offering a searchable database of support services and community resources for enrollees. Enrollee-facing team members continue to be trained with fidelity on how to assess enrollee needs and input them into FindHelp to generate a list of relevant resources within their communities. Within the first two quarters of this year, 134 identifiable unique enrollees have utilized the service with another 1,456 anonymous users, requesting a total of 379 referrals in Q1 and 356 thus far in Q2, covering various needs like housing, food insecurity, new mother support, sober living arrangements, transportation for life events, and financial assistance. We are reinforcing the importance of reporting outcomes for these referrals, implementing closed loop referral improvements such as reducing double data-entry across tracking systems and having Findhelp serve as the source of truth. We are on target to maintain our achievement of 100% utilization of FindHelp by enrollee-facing staff,

consistently reviewing new functionalities on the platform that will further aid in identifying and addressing enrollees' social determinants of health needs. For a summary of the most frequently requested services, refer to Table B1.

B1.2 Sharing SDoH needs with Network Providers – During quarter one and the beginning of quarter two, our primary focus has been on refining our collection of Social Determinants of Health (SDoH) data from various systems (including case management, call center data, and provider-level claims data). This effort aims to enhance the depth and relevance of our understanding of the health disparities experienced by our enrollees. Utilizing the Find Help tool and our updated Health Needs Assessment (HNA), we engage with our enrollees at two key interaction points to identify their needs. We ensure that information gathered through any method is visible to all team members interfacing with an enrollee. Additionally, through our established Health Equity data universe/dashboard, we are also able to look at overall "NEST" scores of our members relative to their communities by zip code, county, and region. The NEST score also gives us a sense if the data we are collecting currently is measuring social vulnerability effectively.

Additionally, we monitor completed assessments, and the number of referrals generated, while assessing our efficiency in closing the loop on these referrals. Looking ahead to December 2024, LHCC is exploring the integration of FindHelp into our TruCare Cloud case management platform. This integration aims to reduce the burden on providers and care managers in assessing and monitoring enrollees' SDoH needs for care plan development/integration.

Lastly, The HE team is engaged with Our Lady of the Lake (OLOL) Health system which has actively integrated FindHelp into their EMR (Electronic Medical Record), to explore the possibilities of implementing real-time closed loop referrals for our members. Additionally, we have created new resource cards with prioritized resources by geographic location for our case management and community health worker teams.

B1.3 Reimbursing Network Providers - Over the past two quarters, we have made significant strides in our development a comprehensive data report that analyzes the intersection of Social Determinants of Health (SDoH) vulnerabilities identified in Health Needs Assessments (HNAs), resource assessments, and our proprietary tools. This report helps us identify potential gaps in preventive care services. One of the latest enhancements includes the ability to compare health equity metrics of our value-based payment providers with all other primary care providers in our network – showing with proper management and support, opportunities for cost savings across the ED (Emergency Department) as well as inpatient settings. To date, there has not been much of a sustained difference when comparing VBP to non-VBP and we are evaluating any potential barriers there. Additionally, we can now evaluate utilization metrics relative to access points across our network and collaborate with community partners to address identified gaps effectively. We remain committed to our goal of using this data to pinpoint areas of greatest need and seek input from our Provider Advisory Council for further refinement. At each PAC meeting, we now have a Health Equity corner where we update our provider champions on opportunities that enhance member experience or positive impacts on provider burden. Our objective is to enhance the integration of our provider network with our case management and community engagement teams.

Looking ahead, we anticipate utilizing the state-developed dashboard to inform our strategic planning, particularly regarding standardized Z code usage reimbursements for our providers. We eagerly anticipate

continued collaboration with the LDH Health Equity leadership team to strengthen our efforts in developing an appropriate reimbursement framework and potentially adding fee schedules that align with our goals and requirements in this regard. In the meantime, we continue to monitor usage in our network with the hopes of piloting a more targeted LHCC specific reimbursement program.

B1.4 Identifying SDoH needs for enrollees – At the close of 2023, LHCC established official policies to enhance our resource assessment methods, aiming to better inform the services provided to enrollees and explore new potential partnerships. During quarters one and two of 2024, we have gathered referral assessment data from 1,509 enrollees. The primary areas of identified Social Determinants of Health (SDoH) needs include assistance with SSI, mental health support, housing, and transportation.

Our ongoing efforts include refining the referral process, and we are progressing well towards our overarching objective of developing, implementing, and leveraging data to effectively address enrollees' SDoH needs. As part of this strategy, we have begun integrating elements such as our Impact Pro score to assess social vulnerability across various care pathways. Additionally, we have done an overhaul of resources outside of FindHelp that could potentially be added to streamline where to search for member resources, but also to streamline internal communication of established partnerships or opportunities to think creatively about collaboration. For example, thus far this year we have added over 140 different resources of small community-based organizations that did not exist on the FindHelp platform. Taking this one step further, we are creating a searchable partner database that will help share more readily accessible information on the health of these partners when examined through an equity lens. This approach ensures that we not only meet but exceed the goals outlined for 2024.

Focus Area (C): Community Approach

C1.1 Neighborhood Health Equity (HE) Project - The LHCC Community Innovations team has achieved considerable progress in establishing connections and partnerships with anchor community entities statewide. These efforts have strengthened our collaboration with SWLA, enhancing our role as a key resource and facilitator in identifying necessary resources and services in Lake Charles and Lafayette. Initially planned under HE 2023, the creation of LHCC-specific Health Equity Neighborhoods has evolved as we discovered existing coalitions and stakeholder groups that already serve as forums for resource sharing, discussion of community concerns, and best practices. By aligning with these established coalitions and stakeholder groups, we aim to maximize resource allocation for greater community impact. This collaborative approach not only enhances our ability to assess health equity but also identifies strategic opportunities for intervention, leveraging their community assessment tools. An example of this is our partnership with Bossier Parish Community College. Through our Equitable Health and Care Collaborative partnership, we held our spring health fair bringing together community vendors of BPCC as well as LHCC, as well as begun collaborating on our Well Woman Shreveport event, where we will utilize BPCC campus as a community hub, involving faculty and students in planning and execution. Stakeholders from across industries have been invited to engage with members and share in a comprehensive day addressing women's health needs within the Shreveport community and beyond. This is an example of leveraging our partnerships for the greater good of the community. We aim to recreate this same collaborative approach with the Delgado College communities as well.

Concurrently, we are closely monitoring the effects of redetermination and enrollee redistribution on access to appropriate care and services, ensuring that our initiatives continue to meet the needs of our enrollees effectively (See Tables C1 and C2 for Racial and ethnic breakdown of redetermination by product type).

C1.2 Community Engagement Activities – We continue to excel in meeting the diverse needs of LHCC enrollees by focusing on individuals while prioritizing community-wide impact to expand our reach. Our commitment to hosting or co-hosting at least one community event per quarter in each region remains strong, as summarized in Table C2. The Community Innovations team is working in close collaboration with the Health Equity team to ensure new partners meet one or more of our HE tenants when applicable. For example, when considering sponsoring community-based programs, we are ensuring they are prepared to capture and share data that speaks to the programs positive impact on improving the overall quality of life of Louisianans. New partners include the Big Brothers Big Sister (BBBS) New Orleans Re-launch, ELZ Elite school of the Performing Arts Summer Camp, Southern University Jags on the Bluff Youth Program, STEM NOLA, LSU (Louisiana State University) School of Nursing as well as many others. Our most recent partnership speaks to health literacy with the Burks Management Firm for the 2024 Youth Financial Literacy Summit to be held at the end of June. This again prioritizes not just the physical but overall health of the member which includes financial health and literacy.

Throughout this year's start, LHCC organized or partnered in 288 events aimed at engaging enrollees and raising awareness about available support services and resources. This represents an increase from 162 events in the first half of 2023. As detailed in tables B2 and B3, these events spanned across the entire state and each region with a focus on leveraging our work on the ground through partnership expansion.

As previously communicated, progress on obtaining community input regarding Social Determinants of Health (SDoH) needs and local lived experiences has been delayed due to unforeseen challenges in receiving LDH approval for our survey concept and materials. The LDH Marketing and Enrollee Education review categorized our survey as a "Focus Group," subject to HPA 15-22 guidelines (referenced in the MME (Marketing and Member Education) Companion Guide, page 18), which imposes restrictions on the data collection process. In the interim, we are collaborating closely with community partners to leverage the data they gather on our communities. For example, at the start of this year we revisited the format of our Member Advisory Council meetings as well as our Community Health Advisory Committee to ensure the information gleaned on member experience is properly digested and reflected in planning moving forward. We have also established a Member Appreciation Meeting that occurs quarterly to show our thanks to members for remaining engaged participants in their care journey.

C1.3 Community Wellness Centers - LHCC is actively shaping the development of our Community Wellness Centers (CWCs) to tailor programming specifically for our enrollees and the broader community. Currently operational in Covington and Lafayette, these centers are pivotal venues for hosting scheduled events such as our member appreciation and advisory council meetings. They also offer enrollees the opportunity to meet with case managers to assess SDoH vulnerabilities and connect them with necessary resources. Furthermore, the centers will continue to evolve and serve as hubs for engaging with resources essential for career development. Looking ahead, we are exploring partnerships with community organizations experienced in workforce development to bring these services to our CWCs. As we establish new partnerships, we offer the centers to organizations for programming purposes. By leveraging our space, we can creatively reach more

members – exercising the social network and coalition theory. Initial feedback has been positive, and our focus for 2024 includes developing methods to track utilization and assess overall impact. Continuing our commitment, we will provide targeted resources and continually evaluate the relevance and effectiveness of our programming in addressing disparities unique to these communities and our enrollees.

C1.4 Community Partnership Expansion – Within the first two quarters of 2024, we continue to meet and surpass our goals set to expand our community footprint through partnership. As previously shared, Louisiana Healthcare Connections has established a 1.5+ million-dollar program to eliminate health disparities and support pathways towards a more inclusive, representative healthcare system. The "Equity in Health and Care initiative" includes community colleges and youth programs in both north and south Louisiana, focusing on diversity and inclusion in the healthcare workforce, as well as economic, and social determinants of health (SDOH). Louisiana Healthcare Connections has made a multi-year investment to create scholarship programs in medical coding, community health work, and allied health programs at Bossier Parish Community College (BPCC) and Delgado Community College (DCC) as well as a Research Fellowship and pipeline program with Xavier University. Each institution is held to the focus areas of the partnership and scope, shared below.

Plan Overview

Purpose	Scope
Health and Equity Scholarships	Fully covers or supplements outstanding cost after financial aid for selected students enrolled in the outlined academic programs.
Academic program support and development	Collaboration with LHCC professionals and BPC/DCC academic staff on workforce development curricula, support academic programs that align with areas of shared focus and/or expansion of online course offerings as needed.
Evaluation and innovation	Collaborate with LHCC to monitor program participation and student success. Identify evolving SDOH and workforce development needs in Louisiana's healthcare and social services. Adapt existing and/or develop new curricula/ programming to address opportunities that are identified.

Since the last report period, these partnerships have grown expeditiously. During Black Maternal Health week, in partnership with Delgado University, we hosted a Speak Up Panel targeting issues facing black and brown birthing women and their partners as they move through their maternal health journeys. The panel consisted of physicians, FQHC (Federally Qualified Health Center) leaders, doulas, nurses, and medical training program leaders touching on the issues that face women every day. After the panel, the room was opened for networking and lite bites. A notable moment from that event was one of our members who is a mom finding joy in being able to connect with her children's PCP (Primary Care Provider) outside of the doctor's office and glean advice on less traditional health needs. As a result of the success of this event, we will be looking to host our Well Woman New Orleans event in partnership with them, like what will be done at BPCC in November of 2024.

Additionally, we have officially launched the research fellowship and pipeline programming with Xavier University. Under the leadership of Dr. Chamika Hawkins- Taylor, we currently offer 4 fellowships for faculty

and student paired research teams in the amount of $16,250 each. The purpose of the research fellowships is to support the forward progress of research studies that examine the impacts of social drivers on the health of Louisianans. Specifically, the proposed studies must touch on one of LHCC's identified areas of concern which includes black maternal health, the foster care landscape, Syphilis, and SDOH in Medicaid. In addition to the fellowships, LHCC will be funding the first Data Science and Informatics track within the Summer Start Institute (SSI) Program. Different from the Star programs, this is a residential 5-week long intensive course that will expose incoming Xavier Freshman to majors and career tracks available to them and bridge content gaps to ensure they are prepared for success in their first year. The program will cover (1) health outcomes, (2) education and equity education, (3) population health, (4) policy and advocacy, and (5) community health. Students will also have access to field experience opportunities specific to Data Science and Informatics in healthcare. The first round of the program kicked off in June with 40 students enrolled and receiving bridge programming specific to data science, informatics, and healthcare.

LHCC will continue to refine our community investment strategy to identify and engage in high impact community-based partnerships. To improve our data collection methods and leveraging the data collected by our partners, each new partner acquired under the Health Equity Plan will receive a data process review that will highlight any potential opportunities for data sharing agreements to enrich our understanding of both our community and enrollees' needs. Within our final mid-year report, we will share the number of scholarships awarded to date.

To date, we have awarded over 50 Health equity scholarships to students with indicated SDOH barriers to continue in their allied health degree and certification programs.

Focus Area (D): Inequities in Care

D1.1 Improve Pregnancy and Birth Outcomes Addressing Inequities Experienced by Black Enrollees –

LHCC has made considerable progress within the first two quarters in its efforts to address inequities facing black birthing individuals within our membership. As previously mentioned, at the end of 2023 LHCC reframed our programing around Black maternal health outcomes and strengthening the use of timely data to be initiative-taking and not just reactive to enrollee's needs. Examining our Maternal Health outcomes through dynamic analysis, we were able to identify key areas of target for 2024. In doing so we have been able to home in on specific processes and seek out partner-based solutions.

LHCC member specific Pregnancy and Birth Outcome Trends

> When examining key influences of making a 1st trimester visit, Parish, Region, Race and Risk score were of impact. When examining Parishes, in comparison to all others, the likelihood of not making one increases for those in Jackson Parish (75%), Union (44%), West Carroll (39%) Lincoln Parish (34%), Jefferson Davis (33%), Allen (31%), Morehouse (29%) or Calcasieu (24%). Regionally, Region 5 saw a 24% increased likelihood of not having made a 1st trimester visit along with region 8 (22%). When examining Risk score, those with a high-risk score had 9% increased odds of not making a 1st trimester visit. Additionally, those that identified as Black saw 8% increased odds when compared to all other race/ethnicities. [See Timeliness of PNV 2023 Data].

When examining key influences of making a 2nd trimester visit, those who had no 1st trimester visit were 3 times more likely to not attend their 2nd trimester visit. Additionally, Jefferson Davis (44%) West Carroll (40%) and Calcasieu (20%) remained significant Parishes of interest. In addition to those, the likelihood of not making one increases for those in Rapides (36%), Acadia (25%), Lafayette (17%) and Iberia (15%). Regionally, Region 5 maintained an increased likelihood of also not making a 2nd trimester appointment (22%) and Region 4 saw an increased likelihood as well (16%). When examining Risk score, those with a moderate risk score had 12% increased odds of not making a 2nd trimester visit. Additionally, those that identified as Black saw a 6% increased odds and Whites 9%. [See Timeliness of PNV 2023 Data]

In examining the likelihood of receiving a c-section compared to vaginal delivery when low risk -there is increased likelihood when Hispanic (14%) and 18% irrespective of risk score. Additionally, those with high-risk scores saw 23% increase in likelihood vs 16% for those with low-risk scores. [See CS rates 2023 Data]

Furthering this is our partnership with Centene Enterprise and Cisco Technologies. This collaboration will Develop a Companion App/Application for MCH (Maternal and Child Health) members with the overall goal of facilitating member access to LHCC's case management and maternity-related services, professionals, and educational content while working to:

- Decrease CM (Care Management) burden while increasing opportunities for members
- Create functional omni-channel solutions (accessible on any device)
- Utilizing existing vendors, partners, and resources to leverage impact

The programs seek to help participants manage low-risk through connection to ready-connect-resources and a multidisciplined team of professionals (consisting of nurses, doulas, and community health workers) which will curate a personalized pregnancy journey complete with the necessary supports to ensure successful pregnancy outcomes. Metrics of interest include an increase in NOPs (Notification of Pregnancy) completed within the first trimester, access to support service referrals, postpartum visits, and child well visits. Discussions will continue around where the application will be hosted, and decision algorithms required to move forward. Internal teams will continue to assess resources and services currently provided and opportunities for enhancement.

In addition to our partner efforts with Cisco, we also enhanced our overall program offerings by having our Community Health Workers complete maternal health certification through Centene University. They are now able to support mothers through their MCH journey. To assess the impacts of this new training on members' experiences, we are piloting the roll out of CHW MCH support in regions 7 & 8 through the end of the year.

On April 11th, in partnership with Delgado University, LHCC hosted a *Speak Up!* event centered on the black maternal health experience. A dynamic panel of impactful leaders across Louisiana addressing how their institutions are addressing disparities facing black women highlighting ways members can advocate for themselves. Panelists included Dr. Courtney Phillips - Advocacy; Dr. Shonda Williams – Nurse; Dr. Joan Ellis, Dean of Nursing; Doula – Shameika Sauseberry; Dr. Tannika Gash, Mental Health. To further make resources

and program updates available to our members, LHCC created a landing page specific to the black maternal health experience, highlighting available resources and opportunities for black birthing members.

Black Maternal Health | Louisiana Healthcare Connections (louisianahealthconnect.com)

Entering the second quarter, the PHCO/HE team has planned to conduct internal focus groups with our front-line staff to better understand from their perspective what LHCC can do to best prioritize and center resources around the members' needs. The focus groups will be hosted over the course of August and cover the following topics: our understanding of the community, how we define a valuable experience, success factors and dependencies of our day-to-day, limitations and barriers, as well as the overall staff experience – all specific to Maternal/Child Health. We plan to use this feedback and newly developed and submitted member survey and focus group frameworks to inform future enhancements to member programming. We are also excited to share the development of a doula pilot program that will offer pregnant enrollees adjunctive services that encourage and support healthy childbirth experiences through support of pregnant persons before, during, and after childbirth. Support may also include birthing, lactation, and parenting classes. Reduction in adverse birth outcomes is this program's main goal by supporting birthing persons using doulas trained and dedicated to providing physical, emotional, and informational support during childbirth. Through this pilot we hope to show the cost effectiveness of doula services as an opportunity for preventative care and healthy engagement. We expect to see roll out of the program in Q4.

D1.2 Enrollee & Family Feedback to Identify & Execute Program Improvements – We are continuing to approach the sourcing of feedback from enrollees and their families with a critical and creative mindset. Our strategy includes stratifying data at all levels by race, ethnicity, geographic region, gender, disability, and other disparities to identify gaps and areas for improvement in both programming and partnerships. Through the Health Equity Universe, we can assess these trends in real time, allowing us to be targeted in our response to member's needs. As previously shared, to enhance our impact, we have shifted our approach to leverage the unique platforms of established community coalitions. This shift has resulted in a significant increase in our presence, with more members attending events on average also increasing opportunities for direct impact. Whereas at the start of 2023 we were not able to provide each region with the same level of programming, as shown in table B2, we are now reaching each region more equitably. This is in part due to the leveraging of our partnerships. Additionally, in Q1 we implemented our first ever Member Appreciation Meeting. This newly established meeting is held quarterly in person and serves as an opportunity to celebrate the members we serve and recognize their diverse needs. It serves as an additional opportunity to glean important feedback on the member experience. This expanded reach has enabled us to gather more extensive anecdotal and formal feedback from both plan enrollees and the broader community, as detailed in Table B2 and B3.

Moving forward, we will continue to utilize the data shared in section E1.2 to guide our efforts and address identified gaps. These achievements affirm that we are on track to successfully meet the goals outlined by December 2024, positioning us well for continued progress in advancing health equity across our member base and communities.

D1.3 Decrease Disparities for Children & Adolescents – We maintain our partnerships with Federally Qualified Health Centers (FQHCs) to deploy their mobile units across communities statewide. This collaboration includes coordinating with Head Start and Early Childhood Centers to conduct dental screenings and provide fluoride varnish treatments. In the first quarter of 2024 alone, we conducted dental screenings for 99 students, with 54 of them being LHCC members. Within our provider network, we have expanded our training initiatives focused on childhood trauma and adversity. These trainings aim to enhance understanding of how environmental factors and non-healthcare behaviors impact overall development. Concurrently, we are advancing our ACEs (Adverse Childhood Experiences) train-the-trainer program. We are actively exploring methods to effectively determine enrollee eligibility for ACE screening and to capture comprehensive data on completion and its impact. These efforts underscore our commitment to proactive healthcare strategies and enhancing outcomes for our enrollees, particularly in addressing childhood health needs and developmental influences.

D1.4 Improve Well-Child Visits and Vaccination Rates - We are progressing well towards achieving our year-end goal of increasing compliance rates by 2%, as indicated in Table D1. While tracking crude rates and aiming for a 2% increase is significant, our focus for 2024 is to adopt a more nuanced approach by identifying statistically significant factors contributing to both compliance and non-compliance. We are integrating Social Vulnerability Index data with insights gathered from community partners to uncover additional factors influencing outcomes for children and adolescents downstream. Leveraging our university partnerships, we continue to host community-based events targeting the whole household. For example, at our events centered on the adult member experience, we also provide childcare support and activities so that the adult can remain focused and engaged. These small inputs impact the overall member experience and their willingness to share impactful feedback.

New to this year's strategy is our focus on the Foster Care Community where we are hosting member appreciation and educational events for both the caregiver and foster child to promote holistic, continuous care. To better understand the needs of this population we implemented a Foster Care dashboard that provides insight into the race, ethnicity, and geographic spread of those members.

Furthermore, we are actively identifying and collaborating with community partners and school networks that align with our efforts to address educational inequities related to vaccinations/immunizations and well-child visits. We aim to provide a detailed breakdown of the progress and expansion of these initiatives in our year-end report. This comprehensive approach underscores our commitment to enhancing compliance rates and addressing disparities effectively.

D1.5 Improve Preventive Dental Services – We continued to show success in deploying mobile dental services despite changes to our ILOS. As dental services are provided only for pediatrics, the number of members eligible and served has decreased. 99 FV were completed in quarter 1, of which 55 were LHCC members. We have created a separate resource listing specific to dental services to ensure we are aware of all dental resources for adult members. We have also trained case managers and community health workers on the preferred resources for our members. The main services targeted through our outreach are oral health screenings/cleanings and fluoride varnishing. Going into the second half of the year, we continue to examine the intersection of dental service need with compliance rates and SDoH factors to identify any additional areas for intervention. We are still on track to meet our Milestone of seeing a 10% increase in oral screenings as well as a 0.5% increase in FVs.

Focus Area (E): Quality Improvement

E1.1 Advancing health equity and enrollee outcomes through the use of CHW (Community Health Workers) and peer support specialists - Our Community Health Workers (CHWs) play a crucial role in ensuring that our enrollees have equitable access to services, resources, and programs tailored to their needs. We have successfully trained our CHWs in Adverse Childhood Experiences (ACEs) education, marking the first step in establishing our internal train-the-trainer model. Upon completing their certifications in collaboration with OPH (Office of Public Health), our CHWs will be equipped to train staff, providers, and various community partners, fostering a trauma-informed system of care. Currently, ACE Certification Courses are not offered frequently throughout the year, making it increasingly difficult to offer this opportunity to more team members. We are hoping to work with the Office of Public Health to better understand how to get more of our CHWs trained. To continuously improve our programming and support services, we regularly convene Enrollee and Community Health Advisory meetings to gather feedback and measure satisfaction with our CHWs and peer support specialists. While we aim to expand our peer specialist team to support community engagement events and partner activities, current resource constraints prevent immediate expansion. In collaboration with PHCO (Population Health and Clinical Operations), our health equity team is exploring innovative approaches to overcome these challenges.

E1.2 RELD (Race, Ethnicity, Language & Disability) and geographic data – To start the year, we have achieved significant milestones in integrating and operationalizing enrollee demographic data received from the state with our internally collected data. Through close collaboration with our data analytics team, we continue to optimize the LHCC Health Equity Universe reporting Dashboard. This dashboard is designed to provide detailed insights into the demographic breakdown of our enrollees, emphasizing our focus on Race, Ethnicity, Spoken Language, Region, Geography Type (rural vs. urban), as well as Zip Code and Parish filters.

The implementation of this dashboard marked a crucial step in centralizing our data sources and establishing a unified source of truth. This advancement enables us to conduct more thorough analyses of disparity data and identify intersections among various demographic factors. By leveraging these improvements, we are better positioned to address health disparities effectively and enhance the overall quality of care for our enrollees.

Enrollees:

As shown in a static snapshot of our dashboard, our total number of Active enrollees at the time of this reporting was 404,542. Our plan enrollees are comprised of 47.3% African American, 35.5% White, ~1% Asian, 0.6% American Indian or Alaskan Native and 0.01% Native Hawaiian or other Pacific Islander. Of those 404K enrollees, 4% Identify as Hispanic or Latino. Approximately 15% of enrollees' race remains unknown. 5,432 of our enrollees that provided no race detail identify as Hispanic (1.75%). 28.5% of enrollees reside in Rural area vs. 70% residing in Urban areas [~1.7% unreported].

Parish - Our top Parishes by number of active enrollees are:

1. East Baton Rouge (8.34%)
2. Calcasieu (7.75%)

3. Orleans (6.85%)
4. Jefferson (6.81%)
5. Tangipahoa (5.3%)
6. Caddo (5.04%)
7. Lafayette (4.93%)
8. Ouachita (4.44%)
9. St. Tammany (4.02%)
10. Rapides (3.22%)

Through further investigation we also see that the top 4-enrollee-dense zip codes for the top three parishes are…

1. East Baton Rouge (8.34%)
    a. 70805 (5,237; 12.52%)
    b. 70816 (3,891; 9.3%)
    c. 70802 (3,638; 8.7%)
2. Calcasieu (7.75%)
    a. 70601 (7,667; 19.72%)
    b. 70607 (5,797; 14.91%)
    c. 70663 (5,416; 13.93%)
3. Orleans (6.85%)
    a. 70117 (4,101; 11.94%)
    b. 70126 (4,095; 11.92%)
    c. 70127 (3,263; 9.5%)
4. Jefferson (6.81%)
    a. 70072 (5,332; 16.61%)
    b. 70058 (4,399; 12.88%)
    c. 70056 (4,064; 11.9%)

We use this data to create feedback reports for each functional area providing up to date and real-time trend analysis, highlighting any potential areas for further evaluation or intervention. For example, our community Innovations team uses this data to inform where it's best to host specific events. By drilling down zip-codes on the foster care dashboard, we best identified where to host our foster care member appreciation event. As previously mentioned in our previous reports, Plan-Do-Study-Act (PDSA) and root cause analysis processes are used to remediate any noted areas for optimization.

To address the inclusion of disability data in our assessment of disparities across programs and services we are collaborating with our community partner, Split Second Foundation, and founder Mark Raymond Jr. to inform the best way to assess impact and thoughtfully interpret LHCC's limited disability data. We will also be working with Split Second to identify additional stakeholders within the community that can help inform the establishment of best practices around the colle4ction of this data moving forward. In Q1, we participated in a wheelchair washday where we connected with community members and gleaned feedback from them on ways LHCC can support our less-abled individuals.

Cultural Responsiveness and Implicit Bias Training

E1.3 CLAS (Cultural and Linguistic Appropriate Services) - LHCC continues its steadfast commitment to addressing the cultural and linguistic needs of its enrollees and the broader community. Tables A1-3 document various training courses completed by providers and LHCC staff aimed at enhancing CLAS (Culturally and

Linguistically Appropriate Services) to better meet the needs of our enrollees. Throughout quarter one and into Q2, we have conducted training sessions covering topics such as Cultural Competency, the impact of language on enrollees' experiences, and the intersection of Social Determinants of Health with mental health needs.

In Q1-2 of 2024, LHCC's call center received 1,524 voice language utilization calls. A significant majority, 96%, requested Spanish language assistance, with smaller numbers requesting Vietnamese and Arabic support. One of the biggest impacts to LSA's metrics is their misalignment with contractual expectations, specifically if a health plan sends in a last minute's request (anything w/in 24hr of the appointment for spoken language and 48hr for ASL) and LSA (Language Service Associates) is not able to provide. LSA was placed on Notice to Cure to improve metrics for face-to-face and over-the-phone metrics. LSA has since remediated both channels. Aligning with expectations has dramatically improved LSA's scoring. These misses in face-to-face translation services were reflected in members reported grievances, however the issues were properly addressed with the provider and members affected.

Through LHCC Health Equity Committee meetings, we have collaboratively established a formal process for collecting enrollee feedback on CLAS standards. This structured approach allows us to incorporate valuable feedback into our programs and services effectively. Furthermore, efforts with our community advisory committee have solidified the identification of bilingual staff. We have identified five staff members who have passed the Bilingual Spanish/English Proficiency test, with three currently serving in enrollee-facing roles. As of Q2 one has left LHCC. These individuals can provide ad-hoc translation services when needed, offering continuity and support in communication efforts.

These initiatives underscore LHCC's ongoing commitment to enhancing cultural competency, improving language access, and ensuring that our services are responsive to the diverse needs of our enrollees and communities.

Tables:

Table A1. Provider and Legacy LHCC Staff Health Equity trainings completed in Q1 – May Q2 2024

Training Title	Audience	Number of Attendees	Length of Training	Training Format
Provider Cultural Competency: Connecting Across Barriers and Language Identification Tool	Provider/ Provider Staff	120	Varies	Live - Provider Visits
Provider Cultural Competency: Connecting Across Barriers and Language Identification Tool	Provider/ Provider Staff	120	Varies	Live -Provider Orientation
TPN Hosted: Advancing Wellness Together	Provider/ Provider Staff	126	2.5 hours	Live
Culturally and Linguistically Appropriate Services (CLAS)	LHCC Staff	*To be assigned in Q4 2024*	30 min	eLearning
LA Cultural Humility: Building Upon the Foundation of Cultural Competency	Provider/ Provider Staff	19	2.5 hours	Live
Social Determinants of Health	Provider/ Provider Staff	6	2 hours	Live
Social Determinants of Health and Mental Health	Provider/ Provider Staff	23	2 hours	Live
Centene: Cultural Humility & Health Equity	LHCC Staff	*To be assigned in Q3 2024*	30 min	eLearning
LHCC Language Assistance Program (LAP) Training	LHCC Staff (Member facing only)	*To be assigned in Q3 2024*	1 hour	eLearning
Impacting Social Drivers and Determinants of Health in Healthcare	LHCC Staff	680/693 (98%)	1 hour	eLearning
Health Literacy Lunch & Learn – Self register event	LHCC Staff	*Offered in Q4 2024*	2 hours	Live

Table A2. New Hire Trainings Assigned Q1 – May Q2 2024

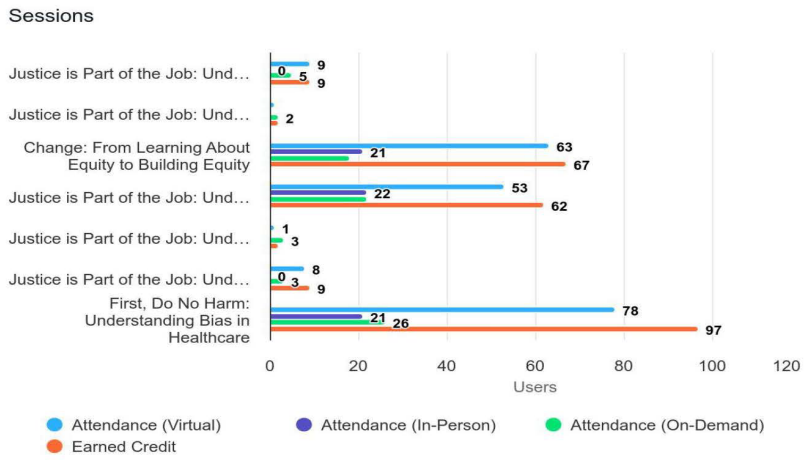
Trainings	Quarter 1 *(LHCC new hires completed/assigned)*	Quarter 2 *(LHCC new hires completed/assigned as of May)*	Quarter 3 *(LHCC new hires completed/assigned)*	Quarter 4 *(LHCC new hires completed/assigned)*
Culturally and Linguistically Appropriate Services (CLAS)	43/57 (75%)	11/18 (61%)		
Centene: Cultural Humility & Health Equity	43/57 (75%)	11/18 (61%)		
LHCC Language Assistance Program (LAP) Training	42/57 (74%)	11/18 (61%)		
Trauma Informed Care (with ACEs) - Live	42/57 (74%)	9/18 (50%)		
Impacting Social Drivers and Determinants of Health in Healthcare	42/57 (74%)	11/18 (61%)		
Health Literacy Lunch & Learn – Live – Self register event	-	-	-	*Offered in Q4 2024*

Table A3. Additional Provider Trainings hosted in Q1 - May Q2 2024 with CEUs

Provider training Topics	Total # of Attendees
Adverse Childhood Experiences - The Study and Beyond	29

Ethics for Mental Health Professionals	3
LA-Person Centered Planning The 4Ps	14
Lesbian Gay Bisexual Transgender Queer Questioning Intersex Asexual Ally	11
Poverty Competency	4
Resiliency and Recovery	6
Trauma Informed Care - Trauma Across the Life Span	17

Figure A1. MCO Collaborative – Advancing Wellness Together Session breakdown for LHCC Providers



This graph shows the breakdown of the three sessions offered within the Advancing Wellness Together Training along with attendance records by virtual, in person or on demand and resulted in an earned credit of completion.

Stratify MCO Results on Attachment H Measures

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