



**State Fiscal Year July 1, 2024–June 30, 2025**

**External Quality Review  
Technical Report**

**for  
AmeriHealth Caritas Louisiana**

*March 2026*



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## 1. Executive Summary

### Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) (collectively referred to as “managed care entities [MCEs]” in this report) for administering Medicaid and Children’s Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality, timeliness, and accessibility of services provided by the contracted MCEs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,<sup>1</sup> with further revisions released in November 2020.<sup>2</sup> 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 (CSoc) 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

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<sup>1</sup> 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 8, 2025.

<sup>2</sup> 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 8, 2025.

health PIHP, CsoC contractor, to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2025 (July 1, 2024–June 30, 2025) 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.<sup>3</sup> For the SFY 2025 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	✓	✓	✓

<sup>3</sup> 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 8, 2025.

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.				
Encounter Data Validation (EDV)	This activity validates the accuracy and completeness of encounter data submitted by an MCO.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan	✓	✓	✓
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	✓		
CAHPS Dental Survey	This activity reports the results of each PAHP’s CAHPS Dental Survey 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	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management (CM) services to determine the number of individuals, the types of conditions, and the impact that CM 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 2025. 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.

		
<p style="text-align: center;"><b>Quality</b></p> <p>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.<sup>1</sup></p>	<p style="text-align: center;"><b>Timeliness</b></p> <p>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.”<sup>2</sup> 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).</p>	<p style="text-align: center;"><b>Access</b></p> <p>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.<sup>1</sup></p>
<p><sup>1</sup> Department of Health and Human Services, Centers for Medicare &amp; 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.</p> <p><sup>2</sup> National Committee for Quality Assurance. <i>2013 Standards and Guidelines for MBHOs and MCOs</i>.</p>		

## 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 2025 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 the overall quality, timeliness, and accessibility of 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<sup>4</sup>

### Strengths

Overall, the quality strategy serves to effectively measure and improve the quality of Louisiana’s Medicaid managed care services. LDH’s initiatives are tied 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

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<sup>4</sup> Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2024–March 19, 2025, November 2025. Louisiana Department of Health. Available at: [https://ldh.la.gov/assets/docs/MQI/LA\\_2025\\_QSE-Report\\_F1.pdf](https://ldh.la.gov/assets/docs/MQI/LA_2025_QSE-Report_F1.pdf). Accessed on: Dec 8, 2025.

Louisiana Medicaid 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 still plans to include the requirement for a commitment to QI in the PAHP contract.

The EQRO has identified the following strengths:

- In support of Goal 3, “Facilitate patient-centered, whole-person care,” the MCEs demonstrated strong adherence to PIP methodology, with most projects scoring 100 percent on critical validation elements and achieving *High Confidence* ratings related to proper study design, data collection, and intervention planning.
- In support of Goal 1, “Ensure access to care to meet enrollee needs,” LDH has established comprehensive network adequacy standards and monitoring processes that support access to care, as demonstrated by strong performance across multiple plan types. All MCEs met or exceeded provider-to-member ratio requirements and key behavioral health timeliness standards, and the PIHP achieved *High Confidence* ratings across all validated indicators with full compliance on appointment access standards. These results reflect a solid oversight structure and a generally adequate provider network to support timely access to behavioral and medical services for most members statewide.

## Recommendations

The EQRO has identified the following recommendations for the quality strategy:

- To improve programwide performance in support of LDH’s quality strategy goals, HSAG recommends that LDH:
  - Establish clear, system-level performance goals within the quality strategy to define the intended direction and outcomes of improvement efforts.
  - Select a streamlined, high-impact set of priority measures that will serve as key indicators of progress toward these goals, reducing the overall number of measures and focusing improvement on LDH’s highest priorities.
  - Ensure all goals and objectives—including those related to PAHPs and PIHPs—are supported by corresponding performance measures within the quality strategy.
  - Define baselines for the selected priority measures to support ongoing measurement, monitoring, and evaluation of performance over time.
  - Refine the measure set by eliminating retired, not reportable, and not applicable measures.
  - Align the quality withhold incentive program with the streamlined priority measure set to ensure that financial incentives are focused on the measures most critical to advancing LDH’s system-level performance goals.

- Strengthen the quality withhold incentive program to be outcome focused, ensuring that withhold payments are earned for demonstrated improvement or sustained high performance on priority measures.
- To improve programwide performance in support of LDH’s quality strategy goals, HSAG recommends that LDH increase its quality strategy evaluation to a three-year period. The evaluation of the effectiveness of the quality strategy should be conducted within the previous three years.
- To target improvement in Goal 2, “Improve coordination and transitions of care,” HSAG recommends that LDH work with the MCOs to improve follow-up after emergency department (ED) and hospital visits for mental health and substance abuse.
- To target improvement in Goal 4, “Promote wellness and prevention,” HSAG recommends that LDH work with the PAHPs to increase the percentage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) enrollees receiving preventative dental services.
- To target improvement in Goal 4, “Promote wellness and prevention,” HSAG recommends that LDH use Medicaid data and performance measure results to identify populations with low rates of preventive and screening services, and require targeted outreach and interventions from the MCEs to increase completion of recommended services.
- To target improvement in Goal 3, “Facilitate patient-centered, whole-person care,” HSAG recommends that LDH strengthen oversight of member-experience performance by aligning CAHPS priorities with the quality strategy’s goals and requiring the MCEs to determine factors contributing to persistently low or stagnant CAHPS scores, and implement focused improvement strategies while promoting interventions shown to improve access, communication, and member engagement.
- To target improvement in Goal 1, “Ensure access to care to meet enrollee needs,” HSAG recommends that LDH require the MCEs to achieve and maintain accurate, complete, and up-to-date provider directories by establishing clear data quality standards, enforcing routine audits, and imposing corrective actions when minimum accuracy thresholds are not met.
- To target improvement in Goal 1, “Ensure access to care to meet enrollee needs,” HSAG recommends that LDH strengthen oversight and collaboration with the dental PAHPs to improve network adequacy in parishes that did not meet distance standards by developing targeted remediation plans, prioritizing recruitment in high-need areas, and implementing ongoing monitoring to ensure members can obtain timely dental care across urban and rural regions.
- To target improvement in Goal 1, “Ensure access to care to meet enrollee needs,” HSAG recommends that LDH strengthen monitoring and follow-through on corrective actions for recurring operational deficiencies related to non-emergency medical transportation (NEMT) timeliness and provider payment to ensure compliance with contract requirements and prevent member access barriers.
- To target improvement in Goal 4, “Promote wellness and prevention,” HSAG recommends that LDH collaborate with the MCEs and providers to improve timely access to prenatal and postpartum care and reduce preventable adverse birth outcomes. Efforts should focus on identifying and addressing barriers to early and continuous prenatal care, implementing provider-level interventions to promote appropriate delivery practices and reduce low-risk cesarean rates, and enhancing outreach and care coordination to support postpartum follow-up and healthy birth outcomes.

### Actions on External Quality Review Recommendations

The EQRO identified the following recommendations for the quality strategy during the last review period, March 20, 2023–March 19, 2024. 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—EQRO Recommendations and LDH Actions**

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
<p>To improve programwide performance in support of LDH’s quality strategy goals, HSAG recommended that LDH identify a measure to align with the following objectives:</p> <ul style="list-style-type: none"> <li>• Ensure appropriate hospice onboarding and transitioning from palliative care to hospice.</li> <li>• Promote early initiation of palliative care to improve quality of life.</li> <li>• Promote health development and wellness in children and adolescents.</li> <li>• Advance specific interventions to address social determinants of health (SDOH).</li> <li>• Advance value-based payment arrangements and innovation.</li> <li>• Ensure members who are improving or stabilized in hospice are considered for discharge.</li> </ul>	<p>LDH has alternative mechanisms to monitor and track these objectives and declines to add new performance measures at this time.</p>
<p>To target improvement in Goal 3, “Facilitate patient-centered, whole person care,” HSAG recommended that LDH include performance measures for the PAHPs and PIHP in the quality strategy.</p>	<p>LDH agrees with this recommendation and has made this change in the upcoming Quality Strategy revisions.</p>
<p>To target improvement in Goal 3, “Facilitate patient-centered, whole person care,” HSAG recommended that LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.</p>	<p>LDH agrees and will incorporate the PAHPs into the MCO PIP process beginning in calendar year (CY) 2026. The PAHPs will use the same submission guidelines and timeline and will also attend quarterly PIP meetings.</p>
<p>To improve programwide performance in support of LDH’s quality strategy goals, HSAG recommended 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</p>	<p>LDH currently works with the MCOs collaboratively during quarterly PIP meetings. LDH works with all MCEs at quarterly MAC meetings. The MAC consists of</p>

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
measures in the quality strategy that have not met improvement objectives and target objectives.	MCE chief medical officers. Best practices are discussed frequently. In addition, LDH meets with the MCO CEOs and other support staff during quarterly business reviews to discuss recommendations and best practices.
To improve MCO performance in Goal 6, “Partner with communities to improve population health and address health disparities,” HSAG recommended that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans (HEPs) and the progress being made through quality interventions to reduce health disparities.	LDH attends MCO quarterly QAPI Committee meetings, where its HEP components and progress being made toward HEP goals are discussed. LDH also reviews and approves the MCOs’ QAPI Plan and related progress reports annually and provides feedback to the MCOs as needed. LDH also provides feedback to the MCOs on their twice-yearly HEP submissions.
To improve programwide performance in support of LDH’s quality strategy goals, HSAG recommended that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.	LDH agrees. These updates were made in the pending revised Quality Strategy.
To target improvement in Goal 1, “Ensure access to care to meet enrollee needs,” HSAG recommended that LDH assess MCO failure to provide NEMT and have the MCOs implement interventions to improve provision of NEMT and ensure it is timely and accessible.	LDH agrees and also assesses MCO failure to provide NEMT and requires the MCOs to 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 recommended that 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.	LDH agrees and already assesses areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty, including identifying root causes and planned interventions through a corrective action plan (CAP).
<p>HSAG recommended that LDH report rates for the following measures included in Appendix B of the quality strategy:</p> <ul style="list-style-type: none"> <li>• <i>Enrollment by Product Line</i></li> <li>• <i>Language Diversity of Membership</i></li> <li>• <i>Race/Ethnicity Diversity of Membership</i></li> </ul>	MCOs are already required to report these measures. They are not included on the Medicaid Quality Dashboard because they are statistical in nature and not performance based.

## Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for AmeriHealth Caritas Louisiana (ACLA) conducted with Louisiana Medicaid managed care throughout SFY 2025.

### *Validation of Performance Improvement Projects*

ACLA actively worked on PIPs throughout SFY 2025, and reported CY 2024 performance indicator results for PIP validation in January 2025. HSAG conducted PIP validation activities from February through April 2025. LDH required ACLA to conduct PIPs on the following state-mandated topics during SFY 2025:

- *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*
- *Behavioral Health Transitions of Care*
- *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*

### *Validation of Performance Measures*

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

### *Information Systems Capabilities Assessment*

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

### *HEDIS—Quality, Timeliness, and Access*

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2024 NCQA national 50th percentile, which served as the benchmark. A total of 44 measures, comprising 185 measure indicators, were selected for analysis. Of the 185 measure indicators, 29 were excluded from comparisons to NCQA national 50th percentile benchmarks: five indicators were excluded from the analysis because they were not reported in Quality Compass for MY 2024; 24 indicators were excluded from the analysis because their rates were not percentages and a percentage point difference could not be determined.

Of the 156 HEDIS measures/measure indicators with an associated benchmark, ACLA had 66 indicators that performed greater than the NCQA national 50th percentile benchmark, 57 that performed lower than the NCQA national 50th percentile benchmark, and one indicator that was not compared to the NCQA national 50th percentile benchmark because the reported rate was *Not Applicable (NA)* (i.e., small denominator). Detailed results are shown in Section 3—Validation of Performance Measures.

### Assessment of Compliance With Medicaid Managed Care Regulations

During 2025, HSAG reviewed 14 standards which represented all federal standards pursuant to 42 CFR Part 438. HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions. For any standard demonstrating less than 100 percent compliance, the MCOs must develop a CAP to address each requirement found to not exhibit full compliance.

**Table 1-4—Summary of CR Scores for the Review Period: CY 2024**

Standard #	Standard Name	CY 2024	MCO Average Results
I	Enrollment and Disenrollment Requirements and Limitations	100%	85%
II	Member Rights and Confidentiality	96%	99%
III	Member Information	67%	69%
IV	Emergency and Poststabilization Services	100%	99%
V	Adequate Capacity and Availability of Services	64%	52%
VI	Coordination and Continuity of Care	83%	85%
VII	Coverage and Authorization of Services	100%	93%
VIII	Provider Selection	79%	70%
IX	Subcontractual Relationships and Delegation	67%	64%
X	Practice Guidelines	100%	97%
XI	Health Information Systems	100%	96%
XII	Quality Assessment and Performance Improvement	100%	100%
XIII	Grievance and Appeal Systems	86%	90%
XIV	Program Integrity	100%	97%
<b>Total Compliance Score</b>		<b>88%</b>	

## Validation of Network Adequacy

### Provider Directory Validation

LDH paused the provider directory validation (PDV) activity for CY 2024; therefore, the PDV results shown are aggregate results for the Quarter (Q)1 and Q2 CY 2025 activity only. Aggregate Q1 through Q4 results will be presented in the SFY 2026 EQR technical report. HSAG’s PDV indicated that, overall, the aggregate Q1 and Q2 provider information maintained and provided by ACLA was inaccurate. Table 1-5 provides a summary of the aggregate Q1 and Q2 findings from the study.

**Table 1-5—Summary of PDV Findings**

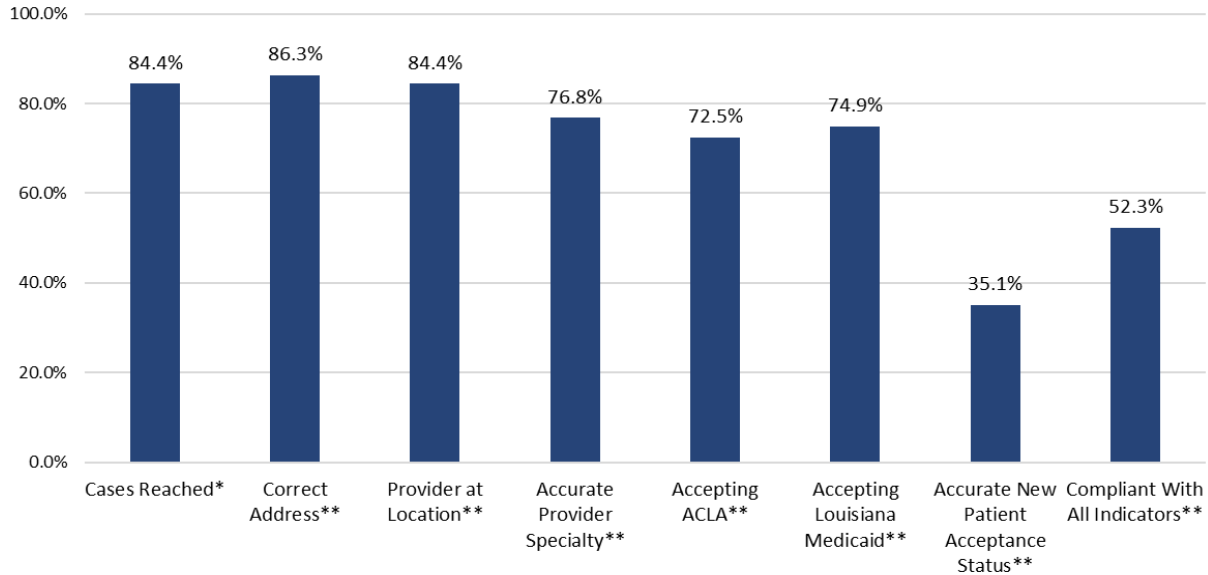
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 74.9 percent of providers accepted Louisiana Medicaid.
Acceptance of ACLA was low.	Overall, 72.5 percent of providers accepted ACLA.
Specialty provider type was incorrect in the provider directory.	Overall, 76.8 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall accuracy of the new patient acceptance status was low. <sup>1</sup>	Overall, 35.1 percent of providers confirmed the new patient acceptance status in the online provider directory was correct.
Affiliation with the sampled provider was low.	Overall, 84.4 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 86.3 percent of respondents reported that ACLA’s provider directory reflected the correct address.

<sup>1</sup>Since sampled cases were not limited to providers accepting new patients, match rates include respondents who confirmed the new patient acceptance status noted in the online provider directory was correct.

While the overall PDV response rate was relatively high at 84.4 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of the Louisiana Medicaid acceptance, ACLA acceptance, and new patient acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate below 87.0 percent.

Figure 1-1 presents the aggregate Q1 and Q2 summary results for all sampled ACLA providers.

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



\*The denominator includes all sampled providers.

\*\*The denominator includes cases reached.

ACLA’s aggregate Q1 and Q2 weighted PDV compliance scores by specialty provider type ranged from 34.0 percent for specialists to 76.0 percent for pediatrics.

### Provider Access Survey

LDH paused the provider access survey activity for CY 2024; however, HSAG conducted two surveys in CY 2025. The survey results shown in this report are for the first biannual 2025 survey only. HSAG’s first provider access survey of 2025 indicated that, overall, the provider information maintained and provided by ACLA was inaccurate. Table 1-6 provides a summary of the findings from the study.

**Table 1-6—Summary of Provider Access Survey Findings**

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 60.0 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 68.8 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, 71.3 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 71.3 percent of providers accepted the requested MCO.

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

**Table 1-7—Provider Access Survey Call Outcomes**

Specialty	Able to Contact <sup>1</sup>	Correct Address <sup>2</sup>	Offering Services <sup>2</sup>	Accepting MCO <sup>2</sup>	Accepting Medicaid <sup>2</sup>	Accepting New Patients <sup>2</sup>	Confirmed Provider <sup>2</sup>
Allergists	94.4%	94.1%	82.4%	70.6%	70.6%	70.6%	58.8%
Dermatologists	100%	100%	100%	81.5%	81.5%	74.1%	66.7%
Orthopedic Surgeons	87.8%	94.4%	94.4%	63.9%	63.9%	63.9%	55.6%
<b>Total</b>	<b>93.0%</b>	<b>96.3%</b>	<b>93.8%</b>	<b>71.3%</b>	<b>71.3%</b>	<b>68.8%</b>	<b>60.0%</b>

<sup>1</sup> The denominator includes all sampled providers.

<sup>2</sup> The denominator includes cases reached.

ACLA’s weighted first provider access survey compliance scores by specialty provider type ranged from 50.4 percent (orthopedic surgeons) to 66.7 percent (dermatologists).

**NAV Audit**

Table 1-8 contains the provider types, at the statewide level, by urbanicity, for which ACLA achieved the 100 percent threshold for 100 percent of members to have access.

**Table 1-8—ACLA Distance Requirements Met by 100 Percent of Members With Access by Provider Type and Urbanicity**

Provider Type	Urbanicity
Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine)	Rural
Rural Health Clinics (RHCs)	Rural
Pharmacy	Rural
Cardiology	Rural
Gastroenterology	Rural
Neurology (Adult)	Rural
Neurology (Pediatric)	Rural
Ophthalmology	Rural
Orthopedics (Adult)	All
Orthopedics (Pediatric)	All
Behavioral Health Specialist (Advanced Practice Registered Nurse—Behavioral Health [APRN-BH] specialty, Licensed Psychologist, or Licensed Clinical Social Worker [LCSW])	Rural

Provider Type	Urbanicity
Psychiatric Residential Treatment Facilities (PRTFs) (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	All
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Rural

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

HSAG assessed ACLA’s results for behavioral health providers to determine the accessibility and availability of appointments and determined that ACLA did not meet any LDH-established performance goals for the three reported appointment access standards, as displayed in Table 1-9.

**Table 1-9—ACLA Appointment Access Standard Compliance Rates 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%	11.5%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	22.5%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	42.0%

### Encounter Data Validation

#### Information Systems Review

The IS review provides self-reported qualitative information from ACLA about its encounter data processes. Table 1-10 summarizes the strengths and weaknesses from the IS review. Cells with a “√” indicate a strength, cells with an “X” indicate a weakness, and cells with an “—” indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

**Table 1-10—Summary of Strengths and Weaknesses From IS Review**

IS Review	ACLA	Note
Encounter Data Sources and Systems	—	None.
Payment Structures	—	None.

IS Review	ACLA	Note
<b>Encounter Data Quality Monitoring</b>		
Processes for Encounters Collected by Subcontractors	✓	Strengths were for NEMT and pharmacy encounters.
Quality Monitoring on Encounters Collected by Subcontractors	✓	Strength was for pharmacy encounters.
Quality Monitoring on Encounters Collected by ACLA	X	Weakness was for missing claim volume and timeliness checks.
% of Encounters Initially Rejected and Not Yet Accepted by LDH	✓	Strengths were for institutional, NEMT, and pharmacy encounters.

### Administrative Profile

The administrative profile analyzes LDH’s encounter data, for ACLA, for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Table 1-11 summarizes the strengths and weaknesses stratified by encounter type. Cells with a “✓” indicate a strength, cells with an “X” indicate a weakness, and cells with an “—” indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation. Of note, ACLA had no dental encounters with dates of service in 2023 in LDH’s data warehouse; therefore, Table 1-11 does not display dental encounter types.

**Table 1-11—Summary of Strengths and Weaknesses From Administrative Profile**

Administrative Profile	Professional	Institutional	Pharmacy
<b>Encounter Data Completeness</b>			
Monthly Encounter Volume per 1,000 MM	—	—	—
Monthly Payment Amount PMPM	—	—	—
TPL Payment Amount PMPM	—	—	—
% of Duplicate Encounters	✓	✓	✓
<b>Encounter Data Timeliness</b>			
Lag Between MCO Payment Date and Received Date by LDH	✓	—	✓
<b>Field-Level Completeness and Accuracy</b>			
% Present	—	—	—
% Valid	X	✓	✓
<b>Encounter Referential Integrity</b>			
Encounter vs Enrollment	—		—
Medical vs Pharmacy Encounter	—		

Administrative Profile	Professional	Institutional	Pharmacy
Encounter vs Provider	—	—	X
<b>Encounter Data Logic</b>			
% of Members Who Had an Encounter	—	—	—
Member Enrollment Continuity	—	—	—

MM = Member Months; PMPM = Per Member Per Month; TPL = Third Party Liability

### Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared ACLA’s 2025 achievement scores to its corresponding 2024 achievement scores and the 2025 NCQA national averages to determine whether there were statistically significant differences.

Overall, ACLA’s 2025 adult achievement score was statistically significantly higher than the 2025 NCQA national average and the 2024 achievement score for *Rating of Personal Doctor*. Additionally, ACLA’s 2025 general child achievement score was statistically significantly higher than the 2025 NCQA national average for *Rating of Personal Doctor*. However, ACLA’s 2025 child achievement score was statistically significantly lower than the 2024 achievement score for *Getting Care Quickly*.

### Behavioral Health Member Satisfaction Survey

HSAG compared ACLA’s 2025 achievement scores to the 2025 Healthy Louisiana statewide average (SWA) and 2024 scores to determine whether there were statistically significant differences.

Overall, ACLA’s 2025 child achievement score was statistically significantly lower than the 2024 achievement score for *Rating of Health Plan*. The rate for *Rating of Health Plan* could be improved by frequently including information about the ratings from the CAHPS survey in provider communications during the year. ACLA could include reminders about the importance of handling challenging patient encounters and emphasizing patient-centered communication for the MCO members.

### Case Management Performance Evaluation

During SFY 2025, HSAG conducted a review of the MCO’s actions to address CAP findings, as identified during the SFY 2024 reviews.

The MCO demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. Specific findings and recommended actions were provided to the MCO through HSAG’s CAP process. The MCO successfully completed remediation actions to address the CAP findings, and the CAP was closed in October 2024.

HSAG will assess the MCO’s implementation of remediation actions during the SFY 2026 reviews.

### Quality Rating System

Figure 1-2 displays the 2025 Health Plan Report Card, which presents the 2025 rating results for each MCO. The 2025 Health Plan Report Card shows that ACLA earned 4.0 stars for the Overall Rating. Additionally, ACLA earned 4.0 stars for the Patient Experience composite, including 5.0 stars and 4.5 stars for the Satisfaction with Plan Physicians and Satisfaction with Plan and Plan Services subcomposites, respectively, demonstrating strength for ACLA in these areas. ACLA also earned 5.0 stars, 4.5 stars, and 4.0 stars for the Equity, Diabetes, and Other Preventive Services subcomposites, respectively, demonstrating strength for ACLA in these areas. However, ACLA earned 2.5 stars for the Women’s Reproductive Health, Respiratory, and Behavioral Health—Care Coordination subcomposites, demonstrating opportunities for improvement for ACLA in these areas.

Figure 1-2—2025 Health Plan Report Card

Issued 07/2025

## 2025 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
<b>Overall Rating*</b>	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
<b>PATIENT EXPERIENCE</b>						
<b>Overall Patient Experience</b>	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
<b>Getting care:</b> How easily and quickly did members get appointments, preventive care, tests, and treatments?	★★★★	★★★★★	★★★★★	—	★★★★★	—
<b>Satisfaction with plan physicians:</b> How happy are members with their primary care doctors?	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
<b>Satisfaction with plan and plan services:</b> How happy are members with their health plan and their overall care?	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
<b>PREVENTION AND EQUITY</b>						
<b>Overall Prevention and Equity</b>	★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★★
<b>Children/adolescent well-care:</b> Do children and adolescents receive weight assessments?	★★★★	★★★★	★★★★	★★★★★	★★★★★	★★★★★
<b>Women’s reproductive health:</b> Do women receive care before and after their babies are born?	★★	★★★	★★★★	★★★	★★★★★	★★★★★

Continued on next page..

Figure 1-2—2025 Health Plan Report Card (cont.)

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
<b>Cancer screening:</b> Do members receive important cancer screenings?	★★★★	★★★★	★★★★	★	★★★★★	★★★★
<b>Equity:</b> Do health plans collect race, ethnicity, and language information from their members?	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★
<b>Other preventive services:</b> Do members receive important preventive services?	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
<b>TREATMENT</b>						
<b>Overall Treatment</b>	★★★★	★★★★	★★★★	★★★★	★★★★	★★★★
<b>Respiratory:</b> Do people with respiratory issues get the services/treatments they need?	★★★	★★★	★★★★	★★★★	★★★	★★★
<b>Diabetes:</b> Do people with diabetes get the services/treatments they need?	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★★★
<b>Heart disease:</b> Do people with heart disease get the services/treatments they need?	★★★★	★★★★	★★	★★★★	★★★★★	★★★★
<b>Behavioral health—care coordination:</b> Do people with behavioral health issues get the follow-up care they need?	★★★	★★★	★★★★	★★★	★★★	★★★
<b>Behavioral health—medication adherence:</b> Do people with behavioral health issues stay on prescribed medications?	★★★★★	★★★★	★★★	★★★★	★★★★★	★★★★★
<b>Behavioral health—access, monitoring, and safety:</b> Do people on behavioral health medications receive the services/monitoring they need?	★★★★	★★★★	★★★★★	★★★★	★★★★	★★★★
	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
<b>Reduce low value care:</b> Do members with low back pain receive unnecessary imaging tests?	★★★★	★★★★	★★★★	★★	★★★★	★★

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

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

*This report card is reflective of data collected between January 2024 and December 2024.*

*The categories and measures included in this report card are based on the 2025 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. The Risk-Adjusted Utilization category was removed because changes in the way the data were calculated and reported prevented comparisons to national data. 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 2025 (review period) was the third year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs, including ACLA, to carry out PIPs to address five state-mandated topics that were validated during SFY 2025. Table 2-1 summarizes the PIP topics carried out by ACLA in SFY 2025.

**Table 2-1—SFY 2025 MCO PIP Topics and Targeted Age Groups**

PIP Topic	Targeted Age Group
<i>Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees</i>	<ul style="list-style-type: none"> <li>• No restrictions</li> </ul>
<i>Behavioral Health Transitions of Care</i>	<ul style="list-style-type: none"> <li>• 6 years and older</li> <li>• 13 years and older</li> </ul>
<i>Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years</i>	<ul style="list-style-type: none"> <li>• 6 months–18 months</li> <li>• 19 months–2 years</li> <li>• 3–5 years</li> </ul>
<i>Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees</i>	<ul style="list-style-type: none"> <li>• 21–64 years</li> </ul>
<i>Screening for HIV Infection</i>	<ul style="list-style-type: none"> <li>• 13 years and older</li> <li>• 15–65 years</li> </ul>

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

Table 2-2 summarizes key PIP validation milestones that occurred from July 2024 through June 2025, the end of SFY 2025.

**Table 2-2—SFY 2025 MCO PIP Activities**

PIP Activities and Milestones	Dates
Monthly collaborative PIP meetings with LDH, the MCOs, and HSAG	July–December 2024
The MCOs submitted Q2 2024 PIP updates	July 2024
The MCOs submitted Q3 2024 PIP updates	October 2024
Quarterly collaborative PIP meetings with LDH, the MCOs, and HSAG	January–June 2025
The MCOs submitted draft PIP reports to HSAG for validation	January 2025
The MCOs submitted Q1 2025 PIP updates	April 2025
HSAG provided draft PIP report validation findings to the MCOs	February 2025
The MCOs submitted final PIP reports to HSAG for validation	March 2025
HSAG provided final PIP validation reports to the MCOs	April 2025

In SFY 2026, ACLA will submit draft PIP reports for initial validation in January 2026 and the final PIP reports for final validation in March 2026. HSAG will complete the third annual validation cycle in April 2026.

### Validation Results and Confidence Ratings

Table 2-3 summarizes ACLA’s final PIP validation results and confidence ratings delivered by HSAG in April 2025.

**Table 2-3—SFY 2025 PIP Validation Results for ACLA**

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements <i>Met</i> <sup>1</sup>	Percentage Score of Critical Elements <i>Met</i> <sup>2</sup>	Confidence Level <sup>3</sup>	Percentage Score of Evaluation Elements <i>Met</i> <sup>1</sup>	Percentage Score of Critical Elements <i>Met</i> <sup>2</sup>	Confidence Level <sup>3</sup>
<i>Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees</i>	100%	100%	<i>High Confidence</i>	<i>Not Assessed</i> <sup>4</sup>		
<i>Behavioral Health Transitions of Care</i>	100%	100%	<i>High Confidence</i>	25%	100%	<i>Moderate Confidence</i>
<i>Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years</i>	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
<i>Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees</i>	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
<i>Screening for HIV Infection</i>	100%	100%	<i>High Confidence</i>	33%	100%	<i>Moderate Confidence</i>

<sup>1</sup> **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

<sup>2</sup> **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*.

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

<sup>4</sup> **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for the PIP.

### Performance Indicator Results

Table 2-4 displays data for ACLA’s *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

For Table 2-4 through Table 2-8, gray shaded cells with an — represent data that will be updated in future remeasurement years, and green shaded cells with a + represent any improvement over the baseline results.

**Table 2-4—Performance Indicator Results for ACLA’s *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP**

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
	N	%					
<i>Syphilis screening during the first pregnancy examination.</i>	N: 740	50.44%	—	—	—	—	<i>Not Assessed</i>
	D: 1,467		—	—	—	—	
<i>Syphilis screening during weeks 28 to 32 of pregnancy.</i>	N: 476	49.22%	—	—	—	—	<i>Not Assessed</i>
	D: 967		—	—	—	—	
<i>Syphilis screening at delivery.*</i>	N: 10	0.64%	—	—	—	—	<i>Not Assessed</i>
	D: 1,570		—	—	—	—	
<i>Syphilis screening at any time during pregnancy or at delivery.</i>	N: 1,472	93.76%	—	—	—	—	<i>Not Assessed</i>
	D: 1,570		—	—	—	—	
<i>Syphilis screening during the first trimester.</i>	N: 365	37.59%	—	—	—	—	<i>Not Assessed</i>
	D: 971		—	—	—	—	
<i>Syphilis screening during the first trimester for all live births.</i>	N: 468	29.81%	—	—	—	—	<i>Not Assessed</i>
	D: 1,570		—	—	—	—	
<i>Syphilis screening during the third trimester for all live births.</i>	N: 449	28.60%	—	—	—	—	<i>Not Assessed</i>
	D: 1,570		—	—	—	—	

N–Numerator D–Denominator

\*The syphilis screening at delivery rate is underreported due to bundled billing.

Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-5 displays data for ACLA’s Behavioral Health Transitions of Care PIP.

**Table 2-5—Performance Indicator Results for 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
	N	%	N	%	N	%	
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 715	17.64%	N: 741	19.55%+ ▲	N: 610	18.77%+	No
	D: 4,053		D: 3,790		D: 3,250		
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 1,389	34.27%	N: 1,408	37.15%+ ▲	N: 1,280	39.38%+ ▲	Yes
	D: 4,053		D: 3,790		D: 3,250		
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 159	22.02%	N: 117	20.71%	N: 97	20.29%	Not Assessed
	D: 722		D: 565		D: 478		
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 243	33.66%	N: 179	31.68%	N: 167	34.94%+	Not Assessed
	D: 722		D: 565		D: 478		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 252	17.15%	N: 141	12.18%	N: 123	14.50%	Not Assessed
	D: 1,469		D: 1,158		D: 848		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 424	28.86%	N: 230	19.86%	N: 215	25.35%	Not Assessed
	D: 1,469		D: 1,158		D: 848		

N=Numerator D=Denominator

▲ 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 activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

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

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

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
	N	D	N	%	N	%	
<i>Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months</i>	N: 295	5.22%	N: 281	8.48%+ ▲	N: 311	8.97%+ ▲	Yes
	D: 5,651		D: 3,315		D: 3,467		
<i>Fluoride varnish application by PCP for children aged 19 months–2 years</i>	N: 585	10.32%	N: 683	11.45%+ ▲	N: 789	14.38%+ ▲	Not Assessed
	D: 5,670		D: 5,965		D: 5,485		
<i>Fluoride varnish application by PCP for children aged 3–5 years</i>	N: 622	5.62%	N: 520	5.77%+ ▲	N: 576	6.88%+ ▲	Not Assessed
	D: 11,073		D: 9,007		D: 8,373		
<i>Fluoride varnish application by PCP for all children aged 6 months–5 years</i>	N: 1,502	6.72%	N: 1,484	8.12%+ ▲	N: 1,676	9.67%+ ▲	Yes
	D: 22,358		D: 18,287		D: 17,325		

N–Numerator D–Denominator

▲ 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 activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

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

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

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
	N	D	N	D			
<i>The percentage of women aged 21–64 years who were screened for cervical cancer</i>	N: 18,158	49.22%	N: 13,920	53.98% +▲	—	—	<i>Not Assessed</i>
	D: 36,891		D: 25,788				

N–Numerator D–Denominator

▲ 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 activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

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

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

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
	N	D	N	D			
<i>Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery</i>	N: 3,496	69.39%	N: 3,089	68.78%	—	—	<i>Not Assessed</i>
	D: 5,038		D: 4,491				
<i>Persons screened for HIV during the measurement year among persons with past or present (injection) drug use</i>	N: 2,405	36.29%	N: 2,243	38.51%+ ▲	—	—	<i>Not Assessed</i>
	D: 6,628		D: 5,825				
<i>Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission</i>	N: 3,568	63.44%	N: 2,811	61.15%	—	—	<i>Not Assessed</i>
	D: 5,624		D: 4,597				

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
	N	%	N	%			
<i>Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection</i>	N: 9,916	8.95%	N: 8,003	8.85%	—	—	<i>Not Assessed</i>
	D: 110,751		D: 90,412		—		

N–Numerator D–Denominator

▲ 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 activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

## Interventions

Table 2-9 summarizes ACLA’s final CY 2024 barriers and interventions.

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

PIP Topic	Barriers	Interventions
<i>Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees</i>	<ul style="list-style-type: none"> <li>Lack of enrollee knowledge on importance of timely prenatal care</li> <li>Lack of motivation or completing priorities to receiving prenatal care</li> </ul>	<ul style="list-style-type: none"> <li>Enrollee outreach/education on importance of timely prenatal care with syphilis screening</li> <li>Enrollee incentive for obtaining prenatal care during pregnancy</li> </ul>
<i>Behavioral Health Transitions of Care</i>	<ul style="list-style-type: none"> <li>Lack of hospital participation in health information exchange</li> <li>Provider difficulty in identifying patients needing follow-up care</li> <li>Lack of enrollee access to care</li> </ul>	<ul style="list-style-type: none"> <li>Utilization of admit, discharge, transfer (ADT) notification report of inpatient admits from FUH population</li> <li>Utilization of ADT notification report of emergency department (ED) admits or discharges from FUM and FUA populations</li> <li>Utilization of ADT notification report to determine CM notification of ED admits or discharges from FUM and FUA populations</li> </ul>

PIP Topic	Barriers	Interventions
<p><i>Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years</i></p>	<ul style="list-style-type: none"> <li>• Lack of access to a dental provider</li> <li>• Lack of provider knowledge that fluoride varnish applications can be done in a PCP office</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced enrollee outreach and education</li> <li>• Enrollee outreach to facilitate dental appointment scheduling</li> <li>• Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) enrollee outreach and education to establish a dental home and facilitate dental provider appointment scheduling</li> </ul>
<p><i>Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees</i></p>	<ul style="list-style-type: none"> <li>• Lack of enrollee knowledge of multiple health conditions and importance of obtaining screening or that screening is due</li> <li>• Providers do not consistently recommend screening for enrollees</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced outreach to assist enrollees with scheduling cervical cancer screening</li> <li>• Outreach and education to provider offices on the availability of gaps in care reports and enrollee and provider incentives, and to assist with any other barriers reported by the provider offices</li> <li>• Q4 provider push with Q4 provider incentive offered outside of Quality Enhancement Program, incentive outreach, and education</li> </ul>
<p><i>Screening for HIV Infection</i></p>	<ul style="list-style-type: none"> <li>• Lack of enrollee knowledge regarding HIV screening guidelines and risk factors</li> <li>• Lack of access to providers</li> <li>• Providers are not aware of their assigned enrollees' HIV screening status or screening guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced outreach for HIV screening for enrollees 15–64 years of age without a diagnosis of HIV</li> <li>• Enhanced telephonic outreach to provide education on HIV screening guidelines for age group 13–20 years and assists with appointment scheduling</li> <li>• Provider education regarding HIV screening guidelines during pregnancy to identify barriers and to notify providers of their enrollees who need screening</li> </ul>

## MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

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

For ACLA, the following opportunity for improvement was identified:

- For two PIPs (*Behavioral Health Transitions of Care* and *Screening for HIV Infection*) assessed for achieving significant improvement, some but not all of the MCO's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For ACLA, the following recommendation was 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]**

## 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).<sup>5</sup>

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.

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<sup>5</sup> 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 8, 2025.

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 access to 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
<i>Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees</i>	✓	✓	✓
<i>Behavioral Health Transitions of Care</i>	✓	✓	✓
<i>Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years</i>	✓	✓	✓
<i>Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees</i>	✓	✓	✓
<i>Screening for HIV Infection</i>	✓	✓	✓

### 3. Validation of Performance Measures

## Results

### *Information Systems Capabilities Assessment*

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

Based on a review of the FARs issued by ACLA’s independent certified HEDIS compliance auditor, HSAG found that ACLA fully met the standard for all four of the applicable NCQA IS standards.

ACLA’s compliance with each of the IS standards is outlined in Table 3-1.

**Table 3-1—ACLA Compliance With IS Standards—MY 2022, MY 2023, and MY 2024 Comparison**

IS Standard	MY 2022	MY 2023	MY 2024
IS R—Data Management and Reporting (formerly IS 6.0, IS 7.0)	Met	Met	Met
IS C—Clinical and Care Delivery Data (formerly IS 5.0)	Met	Met	Met
IS M—Medical Record Review Processes (formerly IS 4.0)	Met	Met	Met
IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	Met	Met	Met

### *Performance Measures*

In SFY 2025 (review period), LDH required each contracted MCO to collect and report on 44 HEDIS measures, which included 185 total measure indicators for HEDIS MY 2024 specified in the provider agreement. The measurement set included nine incentive measures: seven HEDIS and two non-HEDIS incentive measures. Table 3-2 through Table 3-4 display 179 of the 185 HEDIS measure indicators required by LDH, excluding six CAHPS measure indicators also required by LDH.

Table 3-2 through Table 3-5 display a summary of ACLA’s HEDIS measure performance. Red shaded cells with a ^ indicate that the measure fell below the NCQA national 50th percentile, while green shaded cells with a + indicate that the measure was at or above the NCQA national 50th percentile.

**Table 3-2—ACLA HEDIS Effectiveness of Care Performance Measures—  
MY 2022, MY 2023, and MY 2024 Comparison**

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<b>Follow-Up After Hospitalization for Mental Illness</b>				
<i>Within 7 Days of Discharge—Total</i>	18.77%^ <sup>A</sup>	19.82%^ <sup>A</sup>	19.01%^ <sup>A</sup>	22.05%^ <sup>A</sup>
<i>Within 30 Days of Discharge<sup>1</sup>—Total</i>	36.26%^ <sup>A</sup>	38.49%^ <sup>A</sup>	40.09%^ <sup>A</sup>	42.18%^ <sup>A</sup>
<b>Follow-Up After Emergency Department Visit for Mental Illness</b>				
<i>Within 7 Days of Discharge—Total</i>	22.93%^ <sup>A</sup>	20.59%^ <sup>A</sup>	21.60%^ <sup>A</sup>	23.02%^ <sup>A</sup>
<i>Within 30 Days of Discharge<sup>1</sup>—Total</i>	35.30%^ <sup>A</sup>	31.59%^ <sup>A</sup>	36.50%^ <sup>A</sup>	38.77%^ <sup>A</sup>
<b>Follow-Up After Emergency Department Visit for Substance Use</b>				
<i>Within 7 Days of Discharge—Total</i>	17.38%^ <sup>A</sup>	12.51%^ <sup>A</sup>	14.32%^ <sup>A</sup>	15.66%^ <sup>A</sup>
<i>Within 30 Days of Discharge<sup>1</sup>—Total</i>	28.94%^ <sup>A</sup>	20.50%^ <sup>A</sup>	25.00%^ <sup>A</sup>	25.41%^ <sup>A</sup>
<b>Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)</b>				
<i>Within 7 Days of Visit or Discharge—Total</i>	—	—	61.91% <sup>+</sup>	59.23% <sup>+</sup>
<i>Within 30 Days of Visit or Discharge—Total</i>	—	—	73.08% <sup>+</sup>	70.77% <sup>+</sup>
<b>Plan All-Cause Readmissions<sup>B</sup></b>				
<i>Observed Readmissions (Numerator/Denominator)*</i>	10.21%	10.73%	10.18%	10.05%
<i>Expected Readmissions Rate</i>	9.65%	10.04%	8.72%	8.53%
<i>Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)*</i>	1.0574 <sup>A</sup>	1.0691 <sup>A</sup>	1.1677 <sup>A</sup>	1.1771 <sup>A</sup>
<b>Depression Screening and Follow-Up for Adolescents and Adults—Electronic Clinical Data System (ECDS)</b>				
<i>Depression Screening—Total</i>	2.59%	2.37% <sup>+</sup>	2.81%^ <sup>A</sup>	3.31%^ <sup>A</sup>
<i>Follow-Up on Positive Screen—Total</i>	54.11%	51.12%^ <sup>A</sup>	55.32%^ <sup>A</sup>	73.57% <sup>+</sup>
<b>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</b>	84.13% <sup>+</sup>	84.73% <sup>+</sup>	84.59% <sup>+</sup>	85.11% <sup>+</sup>
<b>Diabetes Monitoring for People With Diabetes and Schizophrenia</b>	69.07%^ <sup>A</sup>	71.29% <sup>+</sup>	77.26% <sup>+</sup>	75.60% <sup>+</sup>
<b>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</b>	75.81%^ <sup>A</sup>	80.00% <sup>+</sup>	85.96% <sup>+</sup>	82.56% <sup>+</sup>
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS</b>				
<i>Blood Glucose Testing—Total</i>	—	—	53.75%^ <sup>A</sup>	53.68%^ <sup>A</sup>
<i>Cholesterol Testing—Total</i>	—	—	27.75%^ <sup>A</sup>	28.43%^ <sup>A</sup>
<i>Blood Glucose and Cholesterol Testing—Total</i>	—	—	26.50%^ <sup>A</sup>	27.26%^ <sup>A</sup>
<b>Lead Screening in Children</b>	66.91% <sup>+</sup>	69.83% <sup>+</sup>	66.67%^ <sup>A</sup>	70.87% <sup>+</sup>
<b>Colorectal Cancer Screening<sup>1</sup>—ECDS</b>	—	—	48.16% <sup>+</sup>	45.44% <sup>+</sup>

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
<i>Body Mass Index (BMI) Percentile Documentation—Total</i>	73.20%^A	75.37%^A	80.29%^A	86.26%+
<i>Counseling for Nutrition—Total</i>	62.28%^A	64.39%^A	68.61%^A	70.74%^A
<i>Counseling for Physical Activity—Total</i>	53.35%^A	62.20%^A	66.42%^A	66.86%^A
<b>HIV Viral Load Suppression<sup>1</sup></b>	75.50%	80.81%	82.43%	82.24%
<b>Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)<sup>*,1</sup></b>	23.59%	25.06%	27.38%	26.37%
<b>Chlamydia Screening in Women</b>				
<i>Total</i>	64.40%+	64.32%+	66.28%+	66.43%+
<b>Controlling High Blood Pressure<sup>1</sup></b>	59.90%^A	60.80%^A	66.91%^A	65.03%^A
<b>Statin Therapy for Patients With Cardiovascular Disease</b>				
<i>Received Statin Therapy—Total</i>	81.14%+	83.76%+	84.93%+	82.62%+
<i>Statin Adherence 80%—Total</i>	67.81%^A	68.02%^A	63.64%^A	71.14%^A
<b>Glycemic Status Assessment for Patients With Diabetes</b>				
<i>Glycemic Status &gt;9.0%<sup>*,1</sup></i>	39.66%^A	33.09%+	28.22%+	28.35%+
<i>Glycemic Status &lt;8.0%</i>	53.04%+	59.61%+	66.42%+	64.86%+
<b>Eye Exam for Patients With Diabetes</b>	50.36%^A	51.09%^A	53.28%^A	59.29%+
<b>Blood Pressure Control for Patients With Diabetes</b>	56.20%^A	64.48%^A	72.02%+	69.65%^A
<b>Pharmacotherapy for Opioid Use Disorder</b>	29.55%+	34.07%+	33.01%+	34.64%+
<b>Initiation and Engagement of SUD Treatment</b>				
<i>Initiation of SUD Treatment—Total</i>	64.68%+	65.10%+	65.29%+	59.26%+
<i>Engagement of SUD Treatment—Total</i>	28.33%+	30.10%+	31.55%+	27.37%+
<b>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</b>	60.06%^A	56.83%^A	61.01%^A	64.29%+
<b>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</b>	55.42%^A	57.23%^A	59.37%^A	61.49%^A
<b>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—ECDS</b>				
<i>Initiation Phase</i>	—	—	49.73%+	45.46%^A
<i>Continuation and Maintenance Phase</i>	—	—	57.09%+	52.86%^A
<b>Antidepressant Medication Management</b>				
<i>Effective Acute Phase Treatment</i>	54.72%^A	56.31%^A	57.30%^A	60.88%^A
<i>Effective Continuation Phase Treatment</i>	36.31%^A	38.89%^A	39.02%^A	45.44%^A

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	78.87%^A	80.40%^A	81.59%^A	81.90%^A
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	53.82%^A	54.77%^A	54.73%^A	52.98%^A
<i>Use of Imaging Studies for Low Back Pain</i>	72.61%^A	69.88%^A	71.01%+ <sup>B</sup>	68.86%^A
<i>Cervical Cancer Screening<sup>I</sup></i>	55.36%^A	56.27%^A	58.39%+ <sup>B</sup>	57.33%^A
<b>Asthma Medication Ratio</b>				
5–11 Years	—	80.10%+ <sup>B</sup>	64.12%^A	65.73%^A
12–18 Years	—	72.42%+ <sup>B</sup>	66.94%+ <sup>B</sup>	63.52%^A
19–50 Years	—	71.56%+ <sup>B</sup>	69.36%+ <sup>B</sup>	63.12%+ <sup>B</sup>
51–64 Years	—	69.89%+ <sup>B</sup>	68.65%+ <sup>B</sup>	65.14%+ <sup>B</sup>
Total	—	73.49%+ <sup>B</sup>	67.34%+ <sup>B</sup>	64.22%+ <sup>B</sup>
<b>Appropriate Testing for Pharyngitis</b>				
3–17 Years	—	—	72.38%^A	82.73%^A
18–64 Years	—	—	61.54%^A	78.29%+ <sup>B</sup>
65 Years and Older	—	—	NA	60.61%+ <sup>B</sup>
Total	—	—	69.63%^A	81.44%^A
<b>Topical Fluoride for Children</b>				
1–2 Years	—	6.32%	8.73%	6.04%
3–4 Years	—	9.66%	12.49%	7.59%
Total	—	7.97%	10.68%	6.82%

\* Indicates a lower rate is desirable.

<sup>B</sup> Indicates a break in trending between the most recent year and the prior year.

<sup>I</sup> Incentive Measure.

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/or MY 2023 and indicates that MY 2022 and/or MY 2023 rates are not available for those measures.

**Table 3-3—ACLA HEDIS Accessibility/Availability of Care Performance Measures—  
MY 2022, MY 2023, and MY 2024 Comparison**

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<b>Adults' Access to Preventive/Ambulatory Health Services</b>				
20–44 Years	68.28%^A	68.12%^A	71.91%^A	75.53%^A
45–64 Years	78.39%^A	79.39%^A	81.99%^A	83.48%+ <sup>B</sup>
65 Years and Older	73.00%^A	76.08%^A	80.56%^A	77.97%^A
Total	71.44%^A	71.66%^A	75.29%^A	78.09%+ <sup>B</sup>

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<b>Prenatal and Postpartum Care</b>				
<i>Timeliness of Prenatal Care</i>	85.67%+	80.33%^	76.19%^	83.83%^
<i>Postpartum Care</i>	76.83%^	73.77%^	81.27%^	81.62%^

**Table 3-4—ACLA HEDIS Use of Services and Health Plan Descriptive Information Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison**

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<b>Well-Child Visits in the First 30 Months of Life</b>				
<i>First 15 Months</i>	58.63%+	65.05%+	63.50%+	64.83%+
<i>15 Months–30 Months</i>	63.54%^	69.78%+	72.05%^	72.42%+
<b>Child and Adolescent Well-Care Visits</b>				
<i>3–11 Years</i>	54.64%^	57.12%^	59.52%^	60.45%^
<i>12–17 Years</i>	52.08%+	53.65%+	55.03%+	56.11%+
<i>18–21 Years</i>	26.97%+	28.92%+	32.54%+	32.68%+
<i>Total</i>	48.50%+	51.04%^	53.81%^	54.58%^
<b>Antibiotic Utilization for Respiratory Conditions</b>				
<i>3 Months–17 Years</i>	—	—	33.91%+	34.05%+
<i>18–64 Years</i>	—	—	28.31%+	29.16%+
<i>65 Years and Older</i>	—	—	22.88%+	20.07%+
<i>Total</i>	—	—	32.01%+	32.26%+
<b>Enrollment by Product Line</b>				
<i>Less than 1 Year</i>	—	5,150	3,787	37,522
<i>1–4 Years</i>	—	20,015	17,003	141,537
<i>5–9 Years</i>	—	23,939	21,253	182,737
<i>10–14 Years</i>	—	22,337	19,945	176,938
<i>15–17 Years</i>	—	13,656	12,427	109,211
<i>18–19 Years</i>	—	8,181	6,961	60,260
<i>20–24 Years</i>	—	17,206	12,229	111,685
<i>25–29 Years</i>	—	13,753	9,523	93,717
<i>30–34 Years</i>	—	13,567	9,669	92,906
<i>35–39 Years</i>	—	11,853	8,807	82,628
<i>40–44 Years</i>	—	10,296	7,632	72,625
<i>45–49 Years</i>	—	8,036	6,117	56,774

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<i>50–54 Years</i>	—	6,878	5,072	48,838
<i>55–59 Years</i>	—	7,176	5,316	48,549
<i>60–64 Years</i>	—	6,623	5,122	48,032
<i>65–69 Years</i>	—	267	196	1,704
<i>70–74 Years</i>	—	82	69	620
<i>75–79 Years</i>	—	38	NA	306
<i>80–84 Years</i>	—	NA	NA	200
<i>85–89 Years</i>	—	NA	NA	86
<i>90 Years and Older</i>	—	NA	NA	65
<i>Unknown</i>	—	NA	NA	NA
<i>Total</i>	—	189,108	151,198	1,366,940
<b>Language Diversity of Membership</b>				
<i>Spoken Language Preferred for Health Care—Health Plan</i>	—	39.04%+	45.70%+	51.08%+
<i>Spoken Language Preferred for Health Care—CMS/State</i>	—	60.93%^	54.27%+	47.98%+
<i>Spoken Language Preferred for Health Care—Other Third-Party</i>	—	0.04%+	0.03%+	0.94%+
<i>Preferred Language for Written Materials—Health Plan</i>	—	38.51%+	45.10%+	51.25%+
<i>Preferred Language for Written Materials—CMS/State</i>	—	61.45%+	54.87%+	24.75%+
<i>Preferred Language for Written Materials—Other Third-Party</i>	—	0.04%^	0.03%^	24.00%+
<i>Other Language Needs—Health Plan</i>	—	0.16%+	0.16%^	46.39%+
<i>Other Language Needs—CMS/State</i>	—	99.79%+	99.79%+	20.61%+
<i>Other Language Needs—Other Third-Party</i>	—	0.06%^	0.05%^	33.00%+
<i>Spoken Language Preferred for Health Care—Percent English</i>	—	96.88%+	96.12%+	97.19%+
<i>Spoken Language Preferred for Health Care—Percent Non-English</i>	—	3.05%^	3.85%^	1.86%^
<i>Spoken Language Preferred for Health Care—Percent Declined</i>	—	0.00%+	0.00%+	0.00%+
<i>Spoken Language Preferred for Health Care—Percent Unknown</i>	—	0.07%^	0.03%^	0.95%^
<i>Language Preferred for Written Materials—Percent English</i>	—	96.87%+	96.10%+	65.15%^
<i>Language Preferred for Written Materials—Percent Non-English</i>	—	3.06%+	3.87%^	1.31%^

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<i>Language Preferred for Written Materials—Percent Declined</i>	—	0.00%+	0.00%+	0.00%+
<i>Language Preferred for Written Materials—Percent Unknown</i>	—	0.07%^	0.03%^	33.54%+
<i>Other Language Needs—Percent English</i>	—	98.17%+	98.17%+	37.76%+
<i>Other Language Needs—Percent Non-English</i>	—	1.78%+	1.78%+	0.57%+
<i>Other Language Needs—Percent Declined</i>	—	0.00%+	0.00%+	0.00%+
<i>Other Language Needs—Percent Unknown</i>	—	0.06%^	0.05%^	61.67%^
<b>Race/Ethnicity Diversity of Membership</b>				
<i>Race—Health Plan</i>	—	35.80%+	41.24%+	44.31%+
<i>Race—CMS/State</i>	—	53.72%^	49.10%+	41.33%^
<i>Race—Other Direct</i>	—	0.00%+	0.00%+	1.69%+
<i>Race—Direct Total</i>	—	89.52%+	90.34%+	87.33%+
<i>Race—Indirect Total</i>	—	0.00%+	0.00%+	1.14%+
<i>Race—Unknown Total</i>	—	10.48%^	9.66%^	11.53%^
<i>Ethnicity—Health Plan</i>	—	41.41%+	45.82%+	35.42%+
<i>Ethnicity—CMS/State</i>	—	8.93%^	14.33%^	36.27%+
<i>Ethnicity—Other Direct</i>	—	0.00%+	0.00%+	9.66%+
<i>Ethnicity—Direct Total</i>	—	50.33%^	60.15%^	81.35%^
<i>Ethnicity—Indirect Total</i>	—	0.00%+	0.00%+	4.26%+
<i>Ethnicity—Unknown Total</i>	—	49.67%+	39.85%+	14.39%+
<i>Race: White—Ethnicity: Hispanic or Latino</i>	—	4.05%+	6.12%+	3.01%+
<i>Race: White—Ethnicity: Not Hispanic or Latino</i>	—	14.51%^	15.77%^	32.21%+
<i>Race: White—Ethnicity: Asked but No Answer</i>	—	0.17%+	0.00%+	0.01%+
<i>Race: White—Ethnicity: Unknown</i>	—	16.51%+	13.13%+	2.86%+
<i>Race: White—Ethnicity: Total</i>	—	35.24%^	35.02%^	38.09%^
<i>Race: Black or African American—Ethnicity: Hispanic or Latino</i>	—	4.94%+	7.87%+	3.34%+
<i>Race: Black or African American—Ethnicity: Not Hispanic or Latino</i>	—	21.23%+	23.85%+	37.02%+
<i>Race: Black or African American—Ethnicity: Asked but No Answer</i>	—	0.22%+	0.00%+	0.00%+
<i>Race: Black or African American—Ethnicity: Unknown</i>	—	22.96%+	18.01%+	3.99%+
<i>Race: Black or African American—Ethnicity: Total</i>	—	49.35%+	49.73%+	44.36%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
<i>Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino</i>	—	0.12%+	0.18%+	0.09%+
<i>Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino</i>	—	0.30%+	0.36%+	0.47%+
<i>Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer</i>	—	0.00%+	0.00%+	0.00%+
<i>Race: American Indian or Alaska Native—Ethnicity: Unknown</i>	—	0.35%+	0.24%+	0.21%+
<i>Race: American Indian or Alaska Native—Ethnicity: Total</i>	—	0.78%+	0.78%+	0.77%+
<i>Race: Asian—Ethnicity: Hispanic or Latino</i>	—	0.15%+	0.23%+	0.12%+
<i>Race: Asian—Ethnicity: Not Hispanic or Latino</i>	—	0.46%^	0.50%^	1.53%+
<i>Race: Asian—Ethnicity: Asked but No Answer</i>	—	0.01%+	0.00%+	0.00%+
<i>Race: Asian—Ethnicity: Unknown</i>	—	0.77%+	0.64%+	0.40%+
<i>Race: Asian—Ethnicity: Total</i>	—	1.38%^	1.37%^	2.04%+
<i>Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino</i>	—	0.02%+	0.05%+	0.01%^
<i>Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino</i>	—	0.03%+	0.03%^	0.02%^
<i>Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer</i>	—	0.00%+	0.00%+	0.00%+
<i>Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown</i>	—	0.03%+	0.03%+	0.01%+
<i>Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total</i>	—	0.08%^	0.11%^	0.04%^
<i>Race: Some Other Race—Ethnicity: Hispanic or Latino</i>	—	0.00%^	0.00%^	0.53%+
<i>Race: Some Other Race—Ethnicity: Not Hispanic or Latino</i>	—	0.00%^	0.00%^	1.30%+
<i>Race: Some Other Race—Ethnicity: Asked but No Answer</i>	—	0.00%+	0.00%+	0.00%+
<i>Race: Some Other Race—Ethnicity: Unknown</i>	—	0.00%^	0.00%^	0.70%+
<i>Race: Some Other Race—Ethnicity: Total</i>	—	0.00%^	0.00%^	2.54%+
<i>Race: Two or More Races—Ethnicity: Hispanic or Latino</i>	—	1.21%+	1.96%+	0.27%+
<i>Race: Two or More Races—Ethnicity: Not Hispanic or Latino</i>	—	0.14%+	0.17%+	0.13%+
<i>Race: Two or More Races—Ethnicity: Asked but No Answer</i>	—	0.01%+	0.00%+	0.00%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: Two or More Races—Ethnicity: Unknown	—	1.34%+	1.19%+	0.24%+
Race: Two or More Races—Ethnicity: Total	—	2.70%+	3.33%+	0.64%+
Race: Unknown—Ethnicity: Hispanic or Latino	—	2.04%+	2.54%^	0.99%^
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	0.68%+	0.51%+	3.02%+
Race: Unknown—Ethnicity: Asked but No Answer	—	0.04%+	0.00%+	1.54%+
Race: Unknown—Ethnicity: Unknown	—	7.72%+	6.61%+	5.98%+
Race: Unknown—Ethnicity: Total	—	10.48%^	9.66%^	11.53%^
Race: Total—Ethnicity: Hispanic or Latino	—	12.53%+	18.95%+	8.36%^
Race: Total—Ethnicity: Not Hispanic or Latino	—	37.35%^	41.19%^	75.70%+
Race: Total—Ethnicity: Asked but No Answer	—	0.45%+	0.00%+	1.55%+
Race: Total—Ethnicity: Unknown	—	49.67%+	39.85%+	14.39%+
Race: Total—Ethnicity: Total	—	100.00%+	100.00%+	100.00%+
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Unknown	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Total	—	0.00%+	0.00%+	0.00%+

\* Indicates a lower rate is desirable.

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/or MY 2023, and indicates that MY 2022 and/or MY 2023 rates are not available for those measures.

**Table 3-5—ACLA HEDIS Performance Measure Summary—MY 2022, MY 2023, and MY 2024 Comparison**

Measure Status	MY 2022	MY 2023	MY 2024*
≥ NCQA National 50th Percentile Benchmark	31	173	87
< NCQA National 50th Percentile Benchmark	47	94	63
NCQA National Benchmark Unavailable	11	12	5
<b>Total</b>	<b>89</b>	<b>279</b>	<b>155</b>

\* The “Total” row presents the count of all HEDIS measure indicators that could be reported by ACLA for MY 2024, 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 2024, measure indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator) are excluded from the comparison rows because their results are not comparable to NCQA benchmarks.

## MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- ACLA's rates on the *Follow-Up After High-Intensity Care for SUD* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA was effective in coordinating with providers to ensure that adolescent and adult members diagnosed with SUD who were discharged from an inpatient setting or visited a residential treatment or withdrawal management center received timely and adequate follow-up care to manage their conditions. **[Quality, Timeliness, and Access]**
- ACLA's rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was above the NCQA national 50th percentile benchmark for MY 2024. Additionally, ACLA's rate on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA was effective in ensuring that adult members on antipsychotics were screened for diabetes and had their diabetes monitored, resulting in positive health outcomes for this population. **[Quality]**
- ACLA's rate on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in ensuring that adult members with cardiovascular disease and schizophrenia had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- ACLA's rate on the *Colorectal Cancer Screening—ECDS* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- ACLA's rate on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in coordinating with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- ACLA's rate on the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in coordinating with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) received statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- ACLA's rates on the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0% and Glycemic Status >9.0%* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA was effective in coordinating with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- ACLA's rate on the *Blood Pressure Control for Patients With Diabetes* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**

- ACLA’s rate on the *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in coordinating with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- ACLA’s rates on the *Initiation and Engagement of SUD Treatment* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA was effective in coordinating with providers to initiate treatment for members with a new SUD episode and engaged these members in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment. **[Quality, Timeliness, and Access]**
- ACLA’s rates on the *Follow-Up Care for Children Prescribed ADHD Medication—ECDS* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA effectively coordinated with providers to ensure that children prescribed ADHD medication participated in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescriptions. **[Quality, Timeliness, and Access]**
- ACLA’s rate on the *Use of Imaging Studies for Low Back Pain* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in ensuring that providers properly order imaging studies. **[Quality]**
- ACLA’s rate on the *Cervical Cancer Screening* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA was effective in coordinating with providers to ensure that women ages 21 to 64 years receive appropriate, early detection cancer screening. **[Quality]**
- ACLA’s rates on the following *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024: *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*. These results suggest that ACLA effectively coordinated with providers to help adolescent and adult members with persistent asthma manage this treatable condition. **[Quality]**
- ACLA’s rate on the *Well-Child Visits in the First 30 Months of Life—First 15 Months* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA effectively coordinated with PCPs to ensure that children were seen within the first 15 months of life to assess and influence members’ early development. **[Quality and Access]**
- ACLA’s rates on the *Child and Adolescent Well-Care Visits—12–17 Years* and *18–21 Years* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA effectively coordinated with providers to ensure that adolescent members received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**
- ACLA’s rates on the *Antibiotic Utilization for Respiratory Conditions* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA was effective in coordinating with providers to ensure that members diagnosed with a respiratory condition were not inappropriately dispensed an antibiotic. **[Quality]**

For ACLA, the following opportunities for improvement were identified:

- ACLA's rates on the *Follow-Up After Hospitalization for Mental Illness* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA 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]**
- ACLA's rates on the *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. Additionally, ACLA's rates on the *Follow-Up After Emergency Department Visit for Substance Use* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**
- ACLA's rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- ACLA's rates on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in coordinating with providers to ensure adolescent and adult Medicaid members are properly screened for depression, enabling timely follow-up care. **[Quality]**
- ACLA's rates on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- ACLA's rate on the *Lead Screening in Children* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in ensuring that children under 2 years of age are adequately receiving lead blood testing to ensure they maintain limited exposure to lead. **[Quality]**
- ACLA's rates on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in coordinating with providers to ensure that child and adolescent members are having their weight and BMI monitored, and are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- ACLA's rate on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**

- ACLA’s rate on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in coordinating with providers to ensure that members with ASCVD adhere to statin therapy to effectively manage their condition. **[Quality]**
- ACLA’s rate on the *Eye Exam for Patients With Diabetes* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in coordinating with providers to ensure that adult members with diabetes receive a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- ACLA’s rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in coordinating with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- ACLA’s rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder are dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- ACLA’s rates on the *Antidepressant Medication Management* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in coordinating with providers to treat adult members diagnosed with major depression with antidepressant medication and help members remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**
- ACLA’s rate on the *Appropriate Treatment for Children With URI* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement with ensuring that a diagnosis of URI does not result in an antibiotic dispensing event for members. **[Quality]**
- ACLA’s rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- ACLA’s rate on the *Asthma Medication Ratio—5–11 Years* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in coordinating with providers to help child members with persistent asthma manage this treatable condition. **[Quality]**
- ACLA’s rates on the *Appropriate Testing for Pharyngitis* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in coordinating with providers to ensure that child and adolescent members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**

- ACLA’s rates on the *Adults’ Access to Preventive/Ambulatory Health Services* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in coordinating with PCPs to ensure that adult members are engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- ACLA’s rates on the *Prenatal and Postpartum Care* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care, in alignment with guidance provided by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**
- ACLA’s rate on the *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ACLA has room for improvement in coordinating with PCPs to ensure that children are seen after the first 15 months of life to assess and influence members’ early development. **[Quality and Access]**
- ACLA’s rates on the *Child and Adolescent Well-Care Visits—3–11 Years* and *Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ACLA has room for improvement in coordinating with providers to ensure that child members receive appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For ACLA, the following recommendations were identified:

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

- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators, HSAG recommends that ACLA work with providers to identify root causes and trial interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**
- To improve performance on the *Lead Screening in Children* measure, HSAG recommends that ACLA work with providers to identify and address barriers to lead blood testing in child members. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, and ZIP Code) to identify disparities and implement targeted interventions to increase lead screenings, such as providing patient and provider education. **[Quality]**
- To improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, HSAG recommends that ACLA work with PCPs to identify and address barriers to primary care visits for children and adolescents in need of weight assessment and education on healthy habits. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality]**
- To improve performance on the *Controlling High Blood Pressure* measure, HSAG recommends that ACLA work with providers to identify and address barriers to effective blood pressure management in members. ACLA could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, ACLA could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator, HSAG recommends that ACLA work with providers to identify and address barriers to statin therapy adherence among members with ASCVD. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as provider and member education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that ACLA work with providers to identify and address barriers to retinal eye exams for members with diabetes. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education and outreach campaigns. **[Quality]**
- To improve performance on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure, HSAG recommends that ACLA work with providers to reduce the use of antipsychotics as the first-line treatment and trial solutions to promote psychosocial care as the primary method for addressing the behavioral health needs of child and adolescent members. **[Quality]**

- To improve performance on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that ACLA work with providers to identify and address barriers to the dispensing of antipsychotic medications to members with schizophrenia or schizoaffective disorder, and barriers to adherence to antipsychotic medications. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as provider education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Antidepressant Medication Management* measure indicators, HSAG recommends that ACLA work with providers to identify and address barriers to prescribing antidepressant medication to adult members with major depression and helping members remain on antidepressant medication for the appropriate amount of time. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Appropriate Treatment for Children With URI* measure, HSAG recommends that ACLA work with providers to trial solutions to reduce antibiotic dispensing to treat URIs. ACLA could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, HSAG recommends that ACLA work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. ACLA could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Asthma Medication Ratio—5–11 Years* measure indicator, HSAG recommends that ACLA work with providers to identify and address challenges with access to asthma medication or medication adherence in child members with persistent asthma. ACLA could also consider expanding on existing strategies that focus on disease and chronic condition management, 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 best practices in asthma management. Additionally, ACLA could consider data analysis and stratification across key demographics such as race, ethnicity, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Appropriate Testing for Pharyngitis—3–17 Years* and *Total* measure indicators, HSAG recommends that ACLA work with providers to trial solutions to ensure that child and adolescent members diagnosed with pharyngitis are administered a group A streptococcus test to prevent the inappropriate prescribing of antibiotics. ACLA could also consider data analysis and stratification across key demographics such as race, ethnicity, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, HSAG recommends that ACLA work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities

and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**

- To improve performance on the *Prenatal and Postpartum Care* measure indicators, HSAG recommends that ACLA work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. HSAG recommends that ACLA consider implementing interventions such as offering provider education and engagement opportunities, including educational webinars and newsletters on prenatal and postpartum health services, and piloting a member incentives program designed to encourage engagement in timely prenatal and postpartum care services. **[Quality, Timeliness, and Access]**
- To improve performance on the *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months* measure indicator, HSAG recommends that ACLA work with providers to identify and address barriers to well-child visits for members after the first 15 months of life. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, sending reminders, and incentives for members upon completion of the well-child visits. **[Quality and Access]**
- To improve performance on the *Child and Adolescent Well-Care Visits—3–11 Years* measure indicator, HSAG recommends that ACLA work with providers to identify and address barriers to well-care visits for children. ACLA could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, sending reminders, and incentives for members upon completion of the well-care visits. **[Quality and Access]**

## Methodology

### Objectives

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

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

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

### Technical Methods of Data Collection

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023,<sup>6</sup> 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

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<sup>6</sup> 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 8, 2025.

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 2024 national 50th percentile Medicaid health maintenance organization (HMO) benchmark.

### How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the MY 2024 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
<i>Colorectal Cancer Screening—ECDS</i>	✓		
<i>Cervical Cancer Screening</i>	✓		
<i>Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge—Total and Within 30 Days of Discharge—Total</i>	✓	✓	✓
<i>Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge—Total and Within 30 Days of Discharge—Total</i>	✓	✓	✓
<i>Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge—Total and Within 30 Days of Discharge—Total</i>	✓	✓	✓
<i>Follow-Up After High-Intensity Care for SUD—Within 7 Days of Visit or Discharge—Total and Within 30 Days of Visit or Discharge—Total</i>	✓	✓	✓
<i>Glycemic Status Assessment for Patients With Diabetes—Glycemic Status &gt;9.0% and Glycemic Status &lt;8.0%</i>	✓		
<i>Controlling High Blood Pressure</i>	✓		
<i>HIV Viral Load Suppression</i>	✓		
<i>Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)</i>	✓		
<i>Child and Adolescent Well-Care Visits—3–11 Years, 12–17 Years, 18–21 Years, and Total</i>	✓		✓
<i>Well-Child Visits in the First 30 Months of Life—First 15 Months and 15 Months–30 Months</i>	✓		✓

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

Performance Measure	Quality	Timeliness	Access
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	✓		
<i>Depression Screening and Follow-Up for Adolescents and Adults—ECDS—Depression Screening—Total and Follow-Up on Positive Screen—Total</i>	✓		
<i>Use of Imaging Studies for Low Back Pain</i>	✓		
<i>Asthma Medication Ratio—5–11 Years, 12–18 Years, 19–50 Years, 51–64 Years, and Total</i>	✓		
<i>Appropriate Testing for Pharyngitis—3–17 Years, 18–64 Years, 65 Years and Older, and Total</i>	✓		
<i>Topical Fluoride for Children—1–2 Years, 3–4 Years, and Total</i>	✓		
<i>Antibiotic Utilization for Respiratory Conditions—3 Months–17 Years, 18–64 Years, 65 Years and Older, and Total</i>	✓		
<i>Enrollment by Product Line</i>	NA	NA	NA
<i>Language Diversity of Membership</i>	NA	NA	NA
<i>Race/Ethnicity Diversity of Membership</i>	NA	NA	NA

## 4. Assessment of Compliance With Medicaid Managed Care Regulations

### Results

Table 4-1 presents an overview of the results of the 2025 CR for ACLA. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in the following Methodology section. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards.

**Table 4-1—Summary of Scores for Each Standard**

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				<i>M</i>	<i>NM</i>	<i>NA</i>	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	9	0	3	100%
II	Member Rights and Confidentiality	24	24	23	1	0	96%
III	Member Information	19	18	12	6	1	67%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	9	5	1	64%
VI	Coordination and Continuity of Care	12	12	10	2	0	83%
VII	Coverage and Authorization of Services	23	21	21	0	2	100%
VIII	Provider Selection	19	19	15	4	0	79%
IX	Subcontractual Relationships and Delegation	6	6	4	2	0	67%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	32	5	1	86%
XIV	Program Integrity	18	18	18	0	0	100%
<b>Total Compliance Score</b>		<b>227</b>	<b>217</b>	<b>192</b>	<b>25</b>	<b>10</b>	<b>88%</b>

*M=Met, NM=Not Met, NA=Not Applicable*

**Total Elements:** The total number of elements in each standard.

**Total Applicable Elements:** The **total** number of elements within each standard minus any elements that were *NA*. This represents the denominator.

**Total Compliance Score:** The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

## MCO Strengths, Opportunities for Improvement, Required Actions, and/or Recommendations

For ACLA, the following strengths were identified:

- ACLA achieved a 100 percent compliance score for Standard I—Enrollment and Disenrollment Requirements and Limitations, demonstrating nondiscriminatory enrollment and contractually compliant disenrollment processes under LDH oversight. **[Quality and Access]**
- ACLA achieved a 100 percent compliance score for Standard IV—Emergency and Poststabilization Services, demonstrating that it had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care. **[Quality, Timeliness, and Access]**
- ACLA achieved a 100 percent compliance score for Standard VII—Coverage and Authorization of Services, demonstrating consistent and clinically driven authorization and adverse benefit determination (ABD) notification processes within required authorization time frames as well as compliance with coverage definitions and medical necessity and utilization management standards. **[Quality, Timeliness, and Access]**
- ACLA achieved a 100 percent compliance score for Standard X—Practice Guidelines, demonstrating evidence-based adoption, annual review, provider involvement, LDH approval, broad dissemination, and consistent application in clinical and operational processes. **[Quality and Access]**
- ACLA achieved a 100 percent compliance score for XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]**
- ACLA achieved a 100 percent compliance score for Standard XII—Quality Assessment and Performance Improvement, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; LDH-approved PIPs; and timely reporting to LDH. **[Quality]**
- ACLA achieved a 100 percent compliance score for Standard XIV—Program Integrity, demonstrating a compliant program integrity framework with strong governance; fraud, waste, and abuse (FWA) controls; timely overpayment and service verification processes; rigorous provider screening; and complete reporting and disclosures to LDH. **[Quality]**

For ACLA, the following opportunities for improvement were identified:

- ACLA did not include information within its contracts, trainings, and provider orientation materials that includes the member’s right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations. **[Quality]**
- ACLA’s written materials critical to obtaining services did not meet criteria related to taglines and request for auxiliary aids and services at no cost. **[Quality]**
- ACLA did not make a good faith effort to give written notice within required time frames to members regarding termination of contracted providers. **[Quality, Timeliness, and Access]**
- ACLA did not ensure delivery of the member handbook to members within a reasonable time. **[Quality]**

- ACLA did not include information in the member handbook regarding any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment per State and federal regulations. **[Quality]**
- ACLA's paper and electronic provider directory were missing required components. **[Quality and Access]**
- ACLA's website did not include language informing the member that information that is available in electronic form is available in paper form without charge upon request and that the MCE provides it upon request within five business days. **[Quality]**
- ACLA was not monitoring its provider network to ensure adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. **[Quality and Access]**
- ACLA did not require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**
- ACLA did not ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS) if the provider serves only Medicaid members. **[Quality, Timeliness, and Access]**
- ACLA did not ensure its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- ACLA did not ensure it offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area as well as maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. **[Quality]**
- ACLA's Housing Navigation Services policy did not include Louisiana Medicaid-specific revision/review and approval as contractually required. **[Quality]**
- ACLA's CMPE file review demonstrated noncompliance with timely completion of the initial health needs assessment. **[Quality and Timeliness]**
- ACLA did not have written policies and procedures for retention of network providers that at a minimum meet the requirements of State and federal requirements. **[Quality]**
- ACLA's policies and documents for credentialing and recredentialing did not include language that states the application and attestation include current malpractice insurance coverage, and a current and signed attestation confirming the correctness and completeness of the application. **[Quality]**
- ACLA did not conduct an on-site quality assessment for its providers that are not accredited and must develop a process to ensure that the provider credentials its practitioners. **[Quality]**
- ACLA did not include in its provider's file evidence of the recredentialing decision made by the medical director or credentialing committee, and that decisions must be documented and signed. **[Quality, Timeliness, and Access]**

- ACLA did not ensure that all its contracts or written arrangements comply—and that all delegates agree to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- ACLA did not comport that the contract or written arrangement with subcontractors indicates, and the delegate agrees with, the required federal and State language components within 42 CFR §438.230(c)(3) and 42 CFR §457.1233(b). **[Quality]**
- ACLA did not include in its policies related to grievances and appeals the State requirement to provide the records cited within seven calendar days of receipt of the request from the member. **[Quality and Timeliness]**
- ACLA did not submit the appeal resolution template to LDH for approval. **[Quality]**
- ACLA did not ensure that written consent is obtained when the member requests a State fair hearing (SFH) after receiving notice that the MCE is upholding the ABD related to the appeal. **[Quality]**
- ACLA did not ensure that all grievance and appeal resolution letters meet the state-required reading grade level. **[Quality]**

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

- ACLA must revise its contracts, trainings, and provider orientation materials to include the member’s right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations. **[Quality]**
- ACLA must ensure written materials that are critical to obtaining services are available in the prevalent non-English languages in its service areas and comply with criteria related to taglines and requesting auxiliary aids and services at no cost. **[Quality]**
- ACLA must ensure it makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, and the notice to the member must be provided. **[Quality, Timeliness, and Access]**
- ACLA must ensure delivery of the member handbook to members within a reasonable time. **[Quality]**
- ACLA must include information in the member handbook regarding any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment per State and federal regulations. **[Quality]**
- ACLA must include required components in its paper and electronic provider directory. **[Quality and Access]**
- ACLA must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days. **[Quality]**
- ACLA must monitor, through the collection and analysis of data, its provider network to ensure adequate access to all services for all members, including those with limited English proficiency or physical or mental disabilities. **[Quality and Access]**
- ACLA must meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**

- ACLA must ensure its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS if the provider serves only Medicaid members. **[Quality, Timeliness, and Access]**
- ACLA must ensure, through monitoring and data analysis, its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- ACLA must offer an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of members for the service area as well as maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. **[Quality]**
- ACLA's Housing Navigation Services policy must include Louisiana Medicaid-specific revision/review, and approval as contractually required. **[Quality]**
- ACLA must conduct an initial screening of each member's needs within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. **[Quality and Timeliness]**
- ACLA must implement written policies and procedures for retention of network providers that at a minimum meet the requirements of State and federal requirements. **[Quality]**
- ACLA must have policies and documents that include language that states the application and attestation include current malpractice insurance coverage, and a current and signed attestation confirming the correctness and completeness of the application. **[Quality]**
- ACLA must conduct an on-site quality assessment for its providers that are not accredited and must develop a process to ensure that the provider credentials its practitioners. **[Quality]**
- ACLA must include, in each provider's file, evidence of the recredentialing decision made by the medical director or credentialing committee, and decisions must be documented and signed. **[Quality, Timeliness, and Access]**
- ACLA must ensure that all its contracts or written arrangements comply—and that all delegates agree to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- ACLA must ensure that the contract or written arrangement with subcontractors indicates, and the delegate agrees with, the required federal and State language components within 42 CFR §438.230(c)(3) and 42 CFR §457.1233(b). **[Quality]**
- ACLA must ensure that it includes in its policies the State requirement to provide the records cited within seven calendar days of receipt of the request from the member. **[Quality and Timeliness]**
- ACLA must submit the appeal resolution template to LDH for approval. **[Quality]**
- ACLA needs to ensure that written consent is obtained when the member requests an SFH after receiving notice that the MCE is upholding the ABD related to the appeal. **[Quality]**
- ACLA must ensure that all grievance and appeal resolution letters meet the state-required reading grade level. **[Quality]**

## Methodology

### Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs’ compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the MCEs for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 4-2 outlines the division of standards reviewed for CY 2021, CY 2022, CY 2023, and CY 2024.

**Table 4-2—CR Standards**

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I— Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II— Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III— Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV— Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V— Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI— Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓
Standard VII— Coverage and	§438.210	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Authorization of Services											
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§438.608	✓	✓	✓				-	✓	✓	✓

<sup>1</sup> 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).

\* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

## Technical Methods of Data Collection

Prior to beginning the CR, HSAG developed data collection tools, referred to as “CR tools,” to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs’ compliance were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).<sup>7</sup>

For each of the MCEs, HSAG’s desk review consisted of the following activities.

### Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG’s preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG’s review.

### Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG’s review activities.
- Interviewed MCE key program staff members.
- Conducted an IS review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

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<sup>7</sup> 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.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Dec 8, 2025.

### Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

### Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with the CMS EQR Protocol 3.

*Met* indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

*Not Met* indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, CM, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for CM with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE'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.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

### **Description of Data Obtained**

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.

- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE’s key staff members. Table 4-3 lists the major data sources HSAG used to determine the MCE’s performance in complying with requirements and the time period to which the data applied.

**Table 4-3—Description of MCE Data Sources and Applicable Time Period**

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025–September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

### 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 the MCOs related to the compliance activity conducted.

### How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of 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 accessibility of care and services provided by the MCOs. Table 4-4 depicts assignment of the standards to the domains of care.

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

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

## 5. Validation of Network Adequacy

### Results

#### Provider Directory Validation

HSAG conducted Q1 and Q2 PDV reviews from January through April 2025 (review period). This section presents the aggregate results from the Q1 and Q2 CY 2025 PDV for all sampled ACLA providers by specialty provider type.

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

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

Specialty Provider Type	Response Rate		Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Confirmed New Patient Acceptance Status <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Internal Medicine/ Family Medicine	44	88.0%	38	86.4%	36	81.8%	33	75.0%	31	70.5%	33	75.0%	25	56.8%
Pediatrics	46	92.0%	43	93.5%	44	95.7%	38	82.6%	42	91.3%	42	91.3%	40	87.0%
Obstetricians/ Gynecologists (OB/GYNs)	44	88.0%	39	88.6%	39	88.6%	35	79.5%	32	72.7%	33	75.0%	38	86.4%
Specialists (any)	40	80.0%	27	67.5%	32	80.0%	30	75.0%	21	52.5%	23	57.5%	27	67.5%
Behavioral Health (any)	37	74.0%	35	94.6%	27	73.0%	26	70.3%	27	73.0%	27	73.0%	26	70.3%
<b>Total</b>	<b>211</b>	<b>84.4%</b>	<b>182</b>	<b>86.3%</b>	<b>178</b>	<b>84.4%</b>	<b>162</b>	<b>76.8%</b>	<b>153</b>	<b>72.5%</b>	<b>158</b>	<b>74.9%</b>	<b>156</b>	<b>73.9%</b>

<sup>1</sup> Sampled cases were not limited to providers accepting new patients. Match rates include respondents who confirmed the new patient acceptance status noted in the online provider directory was correct.

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

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

Specialty Provider Type	Total	Compliant <sup>1</sup>	Weighted Compliance Score
Internal Medicine/Family Medicine	50	20	44.0%
Pediatrics	50	34	76.0%
OB/GYNs	50	25	57.3%
Specialists (any)	50	13	34.0%
Behavioral Health (any)	50	24	50.0%
<b>Total</b>	<b>250</b>	<b>116</b>	<b>52.3%</b>

<sup>1</sup> 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.

### Provider Access Survey

HSAG conducted the first provider access survey from April to May 2025 (review period). This section presents the results from the first CY 2025 provider access survey for all sampled providers by MCO and specialty provider type.

Table 5-3 illustrates the response rate and indicator match rates for ACLA by specialty provider type.

**Table 5-3—Response Rate and Indicator Match Rates for ACLA by Specialty Provider Type**

Specialty Provider 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 (%)
Allergists	17	94.4%	16	94.1%	14	82.4%	12	70.6%	12	70.6%	12	70.6%	10	58.8%
Dermatologists	27	100%	27	100%	27	100%	22	81.5%	22	81.5%	20	74.1%	18	66.7%
Orthopedic Surgeons	36	87.8%	34	94.4%	34	94.4%	23	63.9%	23	63.9%	23	63.9%	20	55.6%
<b>Total</b>	<b>80</b>	<b>93.0%</b>	<b>77</b>	<b>96.3%</b>	<b>75</b>	<b>93.8%</b>	<b>57</b>	<b>71.3%</b>	<b>57</b>	<b>71.3%</b>	<b>55</b>	<b>68.8%</b>	<b>48</b>	<b>60.0%</b>

Table 5-4 illustrates the average new patient wait times and appointments meeting compliance standards for ACLA by appointment type.

**Table 5-4—Average New Patient Wait Times and Appointments Meeting Compliance Standards for ACLA by Appointment Type**

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Allergists	42	28.6%
Dermatologists	102	45.5%
Orthopedic Surgeons	18	87.5%

Table 5-5 presents ACLA’s provider access survey weighted compliance scores by specialty provider type. Please see the NAV methodology for the weighted compliance score calculation criteria.

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

Specialty Provider Type	Total Providers Surveyed	Compliant <sup>1</sup>	Weighted Compliance Score <sup>2</sup>
Allergists	18	10	64.8%
Dermatologists	27	18	66.7%
Orthopedic Surgeons	41	20	50.4%
<b>Total</b>	<b>86</b>	<b>48</b>	<b>58.5%</b>

<sup>1</sup> 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.

<sup>2</sup> The compliance scores in this section represent the weighted compliance score for each MCO and specialty and are not a calculation of the compliant providers divided by the total. The criteria in Table 5-11 and Table 5-12 of the Methodology section were used to calculate the weight of each noncompliance survey outcome.

## NAV Audit

This section presents the results from the CY 2024 (review period) NAV audit.

### Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCE according to the CMS EQR Protocol 4. *Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS

EQR Protocol 4).<sup>8</sup> Table 5-5 presents a summary of the NAV validation ratings for ACLA by network adequacy standard type.

**Table 5-6—Summary of ACLA Validation Ratings by Standard Type**

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not be Validated
Time and Distance	100%	0%	0%	0%	0%
Provider-to-Enrollee Ratios	100%	0%	0%	0%	0%
Access and Availability	100%	0%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 96 indicators for ACLA. Of these indicators, 100 percent received *High Confidence* ratings.

### Access Standards

Table 5-7 contains the percentage of members ACLA 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 and marked with an up arrow.

**Table 5-7—ACLA Distance Requirements Met by Percentage of Members With Access by Provider Type and Urbanicity**

Provider Type	Urbanicity	Percentage of Members With Access
Adult PCP (Family/General Practice; Internal Medicine)	Urban	96.5%
	Rural	100% ↑
Pediatrics (Family/General Practice; Internal Medicine)	Urban	90.0%
	Rural	98.7%
Federally Qualified Health Centers (FQHCs)	Urban	84.5%
	Rural	99.9%
RHCs	Urban	44.4%
	Rural	100% ↑
Acute Inpatient Hospitals	Urban	89.2%
	Rural	99.3%
Laboratory	Urban	98.2%
	Rural	99.7%

<sup>8</sup> 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.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Dec 8, 2025.

Provider Type	Urbanicity	Percentage of Members With Access
Radiology	Urban	97.7%
	Rural	99.5%
Pharmacy	Urban	96.9%
	Rural	100% ↑
Hemodialysis Centers	Urban	88.7%
	Rural	97.8%
OB/GYNs (access only for adult female members ages 21 and over)	Urban	93.2%
	Rural	89.2%
Allergy/Immunology	Urban	99.9%
	Rural	98.5%
Cardiology	Urban	99.9%
	Rural	100% ↑
Dermatology	Urban	95.7%
	Rural	82.5%
Endocrinology and Metabolism (Adult)	Urban	95.6%
	Rural	99.7%
Endocrinology and Metabolism (Pediatric)	Urban	97.1%
	Rural	99.8%
Gastroenterology	Urban	99.9%
	Rural	100% ↑
Hematology/Oncology	Urban	99.9%
	Rural	97.7%
Nephrology	Urban	99.9%
	Rural	97.7%
Neurology (Adult)	Urban	99.9%
	Rural	100% ↑
Neurology (Pediatric)	Urban	99.9%
	Rural	100% ↑
Ophthalmology	Urban	99.9%
	Rural	100% ↑
Orthopedics (Adult)	Urban	100% ↑
	Rural	100% ↑
Orthopedics (Pediatric)	Urban	100% ↑
	Rural	100% ↑
Otorhinolaryngology/Otolaryngology	Urban	99.9%
	Rural	98.5%
Urology	Urban	99.9%
	Rural	98.7%

Provider Type	Urbanicity	Percentage of Members With Access
Psychiatrists	Urban	93.4%
	Rural	99.9%
Physicians and licensed mental health practitioners (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders	Urban	94.9%
	Rural	93.3%
Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD	Urban	79.5%
	Rural	34.6%
Behavioral Health Specialist (Advanced Practice Registered Nurse—Behavioral Health [APRN-BH] specialty, Licensed Psychologist, or LCSW)	Urban	99.0%
	Rural	100% ↑
PRTFs (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21)	All	100% ↑
American Society of Addiction Medicine (ASAM) Level 1	Urban	90.3%
	Rural	92.8%
ASAM Level 2.1	Urban	86.6%
	Rural	81.8%
ASAM Level 2 WM	Urban	75.8%
	Rural	71.4%
ASAM Level 3.1 (Adult over age 21)	Urban	88.1%
	Rural	12.2%
ASAM Level 3.1 (Pediatric under age 21)	All	87.9%
ASAM Level 3.2 WM (Adult over age 21)	Urban	77.0%
	Rural	60.1%
ASAM Level 3.2 WM (Pediatric under age 21)	All	63.1%
ASAM Level 3.3 (Adult over age 21)	Urban	77.7%
	Rural	55.0%
ASAM Level 3.5 (Adult over age 21)	Urban	91.4%
	Rural	60.4%
ASAM Level 3.5 (Pediatric under age 21)	All	98.4%
ASAM Level 3.7 (Adult over age 21)	Urban	95.3%
	Rural	95.3%
ASAM Level 3.7 WM (Adult over age 21)	Urban	95.3%
	Rural	95.3%
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	99.9%
	Rural	100% ↑

Provider Type	Urbanicity	Percentage of Members With Access
Mental Health Rehabilitation (MHR) Agency (Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention—MHR Agency [Legacy MHR], Behavioral Health Rehab Provider Agency [Non-Legacy MHR]; Mental Health Clinics)	Urban	92.2%
	Rural	99.3%

**Provider-to-Member Ratios**

HSAG assessed ACLA’s results for combined adult PCP and combined pediatrics provider-to-member ratios at the statewide level. The statewide level consists of nine LDH regions, which indicated ACLA’s statewide results met or exceeded LDH-established requirements. Table 5-8 displays the statewide combined adult PCP and combined pediatrics provider-to-member ratios.

**Table 5-8—ACLA Statewide Combined Adult PCP and Combined Pediatrics Provider-to-Member Ratios**

Provider Type	Indicator	Compliant
<b>Statewide Combined Ratio</b>		
Combined Adult PCP Full-Time Equivalents (FTEs) (1:1,000 adult members)	2.44%	Yes
Combined Pediatrics (1:1,000 child members)	1.30%	Yes

HSAG assessed ACLA’s results for statewide provider-to-member ratios by specialty provider type and determined that ACLA’s statewide results met or exceeded LDH-established requirements. Table 5-9 displays the statewide provider-to-member ratios by specialty provider type and indicator.

**Table 5-9—ACLA Statewide Provider-to-Member Ratios by Specialty Provider Type**

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
OB/GYNs	1:10,000	0.04%	Yes
Allergy/Immunology	1:100,000	0.01%	Yes
Cardiology	1:20,000	0.05%	Yes
Dermatology	1:40,000	0.02%	Yes
Endocrinology and Metabolism	1:25,000	0.01%	Yes
Gastroenterology	1:30,000	0.01%	Yes
Hematology/Oncology	1:80,000	0.02%	Yes
Nephrology	1:50,000	0.02%	Yes
Neurology	1:35,000	0.05%	Yes

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
Ophthalmology	1:20,000	0.03%	Yes
Orthopedics	1:15,000	0.02%	Yes
Otorhinolaryngology/Otolaryngology	1:30,000	0.02%	Yes
Urology	1:30,000	0.01%	Yes

HSAG assessed ACLA’s results for behavioral health providers to determine the accessibility and availability of appointments and determined that ACLA did not meet any of the LDH-established performance goals for three reported appointment access standards. Table 5-10 displays the performance measure, threshold, LDH-established performance goal, and achieved compliance rate.

**Table 5-10—ACLA Appointment Access Standard Compliance Rates 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%	11.5%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	22.5%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	42.0%

## MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- Overall, 96.3 percent of respondents in the provider access survey confirmed the sampled address was correct. **[Quality and Access]**
- In the provider access survey, 100 percent of the respondents confirmed the location provided dermatology and orthopedic surgeon services. **[Quality and Access]**
- No strengths were identified in the PDV activity, as all indicators had match rates below 90 percent.
- ACLA demonstrated strong provider data validation and engagement practices by conducting weekly on-site visits to verify demographic and access information and provide ongoing education. Additionally, ACLA conducted monthly secret shopper outreach calls to confirm appointment availability and after-hours access, ensuring consistent compliance with access requirements across the network. **[Quality and Access]**

For ACLA, the following opportunities for improvement were identified:

- Acceptance of ACLA was inaccurate with 72.5 percent of providers in the PDV and 71.3 percent of locations in the provider access survey accepting ACLA. Additionally, 74.9 percent of providers in the PDV and 71.3 percent of locations in the provider access survey accepted Louisiana Medicaid. **[Quality and Access]**
- Overall, only 76.8 percent of providers in the PDV confirmed the specialty was accurate. Additionally, 82.4 percent of allergist locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**
- Overall, acceptance of new patients was relatively low with 73.9 percent of providers in the PDV and 68.8 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 84.4 percent of PDV locations and 60.0 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Of the limited number of cases that offered an appointment, 28.6 percent of allergist cases, 45.5 percent of dermatologist cases, and 87.5 percent of orthopedic surgeon cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by survey type with an overall compliance score of 52.3 percent for the PDV and 58.5 percent for the provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with specialists having the lowest compliance score at 34.0 percent and pediatrics having the highest compliance score at 76.0 percent for the PDV. For the provider access survey, orthopedic surgeons exhibited the lowest compliance score at 50.4 percent, and dermatologists exhibited the highest compliance score at 66.7 percent. **[Quality and Access]**
- In preparation for the semiannual LA 220 report, ACLA reported an incorrect distance of 11 miles instead of the 10-mile radius for urban RHC adult members, resulting in inaccurate calculations for this provider type. **[Quality]**
- ACLA did not report adult and pediatric populations separately for three specialty provider types (i.e., endocrinology and metabolism, neurology, and orthopedics) in accordance with LDH contractual standards. **[Quality]**

For ACLA, the following recommendations were identified:

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

- ACLA should consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care timely. [**Timeliness and Access**]
- ACLA should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active providers, telephone number, new patient acceptance). LDH could consider developing time frames and monitoring procedures (e.g., provider portals, data submissions) for ACLA to confirm office outreach and confirmation of provider information. [**Quality and Access**]
- ACLA should enhance its QA process by implementing a standardized pre-submission validation checklist to confirm that all parameters and configuration settings used for geo-access reporting align with current LDH standards and contract requirements. [**Quality**]
- ACLA should work with LDH to ensure a clear understanding of the expectations for separating adult and pediatric populations for reporting time and distance results for the specialty provider types (i.e., endocrinology and metabolism, neurology, and orthopedics). [**Quality**]

## 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. 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 January through April 2025. 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, specialty provider type, provider affiliation with the requested MCO, provider’s acceptance of Medicaid, and accuracy of new patient acceptance status.

### Provider Access Survey

HSAG conducted the first provider access survey from April to May 2025. 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 Identifier (NPI) number, specialty provider type, 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 specialty provider type 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 2025:

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 specialty provider type

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

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 5-11 were used to calculate the weight of each noncompliance survey outcome.

**Table 5-11—Noncompliance Reasons and Weighting**

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
New patient acceptance mismatch	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 provider type reported	1
Refused to participate in survey	0

**Table 5-12—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 5-11. If multiple noncompliance criteria were 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  $\geq 75$ .

### 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 specialty provider type
- 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 5-13 were used to calculate the weight of each noncompliance survey outcome.

**Table 5-13—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 provider type reported	1
Refused to participate in survey	0

**Table 5-14—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 5-13. If multiple noncompliance criteria were 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:

$$\text{MCO's weighted compliance score} = 1 - \text{the weighted noncompliance score}$$

Compliance: The MCOs were compliant if their weighted compliance score was  $\geq 75$  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 5-15.

**Table 5-15—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 5-16.

**Table 5-16—Validation Score Calculation**

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Validation Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> 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 5-17 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

**Table 5-17—Indicator-Level Validation Rating Categories**

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

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 5-18.

**Table 5-18—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. Encounter Data Validation

### Results

Representatives from ACLA completed the LDH-approved questionnaire supplied by HSAG through the Universal Survey Tool (UST). HSAG identified follow-up questions based on ACLA’s original questionnaire responses, and ACLA responded to these specific questions. To support its questionnaire responses, ACLA submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from ACLA regarding its encounter data processes.

The administrative profile analyzed LDH’s encounter data for completeness, timeliness, and accuracy by evaluating data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of LDH’s data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 6-1 provides a list of multifaceted analyses conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of LDH’s encounter data from ACLA.

**Table 6-1—EDV Results for ACLA**

Analysis	Key Findings
<b>IS Review</b>	
Encounter Data Sources and Systems	<ul style="list-style-type: none"> <li>• ACLA and its subcontractors demonstrated their capability to collect, process, and transmit encounter data to LDH, as well as develop data review and correction processes that can respond to quality issues identified by LDH.</li> <li>• ACLA reported methods to identify duplicate claims.</li> <li>• ACLA and its subcontractors were responsible for the collection and maintenance of the provider information. In addition, ACLA and its subcontractors integrated the Medicaid member enrollment files into their systems for claim processing.</li> </ul>
Payment Structures	<ul style="list-style-type: none"> <li>• ACLA reported a wide range of pricing methodologies that varied by encounter type and subcontractors.</li> <li>• ACLA collected and verified TPL information, processed payment based on TPL information, and submitted TPL information to LDH via the encounter data.</li> </ul>
Encounter Data Quality Monitoring	<ul style="list-style-type: none"> <li>• ACLA stated that it had subcontractors for NEMT and pharmacy encounters. For the encounters collected by these subcontractors,</li> </ul>

Analysis	Key Findings
	<p>ACLA noted that it stored and reviewed encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH.</p> <ul style="list-style-type: none"> <li>• ACLA and/or its subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on these encounters collected by subcontractors except the claim volume check on NEMT encounters.</li> <li>• For encounters collected by ACLA, ACLA noted that it performed completeness and accuracy and reconciliation with financial reports checks.</li> <li>• Based on ACLA’s responses to the questionnaire, the percentage of encounters that were initially rejected and not yet accepted by LDH varied from 0.1 percent (NEMT encounters) to 1.5 percent (non-subcontractor professional encounters).</li> </ul>
<b>Administrative Profile</b>	
Encounter Data Completeness	<ul style="list-style-type: none"> <li>• ACLA displayed consistent encounter volume per 1,000 MM, payment amount PMPM, and TPL payment amount PMPM for professional, institutional, and pharmacy encounters throughout the measurement year. In addition, ACLA had no dental encounters during the measurement year.</li> <li>• ACLA had a rate of duplicate encounters of less than 1.0 percent for each of the three encounter types listed above.</li> </ul>
Encounter Data Timeliness	<ul style="list-style-type: none"> <li>• Within 60 days, ACLA submitted 98.2 percent of professional, 97.6 percent of institutional, and 99.4 percent of pharmacy encounters to LDH after the payment date.</li> </ul>
Field-Level Completeness and Accuracy	<ul style="list-style-type: none"> <li>• All key data elements in ACLA’s encounter data had a relatively high or reasonable rate of population (i.e., percent present).</li> <li>• ACLA had all key data elements populated with at least 95.0 percent of valid values in institutional and pharmacy encounters, while there was at least one data element with an accuracy rate below 95.0 percent for the professional encounters. Refer to the opportunities for improvement section below for the data element needing ACLA’s attention.</li> </ul>
Encounter Referential Integrity	<ul style="list-style-type: none"> <li>• No major concerns were noted for ACLA when evaluating the integrity between medical/pharmacy encounters and member enrollment data or between medical encounters and pharmacy encounters.</li> <li>• Of all identified provider NPIs in ACLA’s submitted medical and pharmacy encounters, only 94.3 percent and 86.8 percent were identified in the provider data, respectively.</li> </ul>

Analysis	Key Findings
Encounter Data Logic	<ul style="list-style-type: none"> <li>• ACLA had 56.0 percent of members with both medical and pharmacy encounters throughout the measurement year.</li> <li>• ACLA had 71.7 percent of members who were continuously enrolled in the measurement year.</li> </ul>

## MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- For the encounters collected by its subcontractors, ACLA noted that it stored and reviewed encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH. In addition, ACLA and/or its pharmacy subcontractor noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on pharmacy encounters. **[Quality and Timeliness]**
- ACLA reported less than 1.0 percent of institutional, pharmacy, and NEMT encounters as initially rejected and not yet accepted. **[Quality]**
- ACLA had low duplicate rates for professional encounters (0.3 percent), institutional encounters (0.1 percent), and pharmacy encounters (<0.1 percent). **[Quality]**
- ACLA submitted 98.2 percent of professional encounters and 99.4 percent of pharmacy encounters within 60 days from the payment date. **[Timeliness]**
- For institutional and pharmacy encounters, ACLA had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**

For ACLA, the following opportunities for improvement were identified:

- ACLA did not report performing claim volume and timeliness checks on encounters collected by the MCE (i.e., non-subcontractor data). **[Quality and Timeliness]**
- ACLA had no dental encounters with dates of service in 2023 in LDH’s data warehouse. **[Quality]**
- ACLA had the following data element with less than 95.0 percent of valid values:
  - Professional Encounters: *National Drug Codes (NDCs)* (93.1 percent) **[Quality]**
- For referential integrity, ACLA had a low percentage of providers in the pharmacy encounter file who were also in the provider file at approximately 86.8 percent. **[Quality]**

For ACLA, the following recommendations were identified:

- ACLA should build additional encounter data quality monitoring reports to evaluate encounter data completeness and timeliness. **[Quality and Timeliness]**
- ACLA should work with LDH to determine whether ACLA had dental encounters with dates of service in 2023 that should be submitted to LDH. **[Quality]**

- ACLA should investigate the root causes for the data element with less than 95.0 percent of valid values (i.e., the one listed in the opportunities for improvement section) to improve accuracy. **[Quality]**
- ACLA should work with LDH to ensure both entities have an accurate and complete database of contracted providers for the pharmacy encounters. **[Quality]**

## Methodology

### Objectives

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, LDH requires its contracted Medicaid MCEs to submit high-quality encounter data. LDH relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2024–2025, LDH contracted with HSAG to conduct an EDV study consisting of the following two activities:

- IS review—assessment of LDH's and the MCEs' IS and processes. The goal of this activity was to examine the extent to which LDH's, and the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's [Managed Care Plan's] capability in the CMS EQR Protocol 5. *Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).<sup>9</sup>
- Administrative profile—analysis of LDH's electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the electronic encounter data in LDH's data warehouse are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from January 1, 2023, through December 31, 2023. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

### Technical Methods of Data Collection

#### Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- **Stage 1—Document Review:** HSAG conducted a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by LDH. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, LDH's current encounter data submission requirements, and other relevant materials. The information obtained

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<sup>9</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: 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 8, 2025.

from this review was important for developing a targeted questionnaire to address important topics of interest to LDH.

- **Stage 2—Development and Fielding of Customized Encounter Data Assessment:** HSAG first evaluated the MCEs’ most recent ISCA, if available, to assess whether the information is complete and up to date. This process allowed these activities to be coordinated across projects, preventing duplication, and minimizing the impact on the MCEs. HSAG then developed a questionnaire customized in collaboration with LDH to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, this review included specific topics of interest to LDH. For example, the reviews included questions regarding how MCEs ensure their subcontractors are submitting timely, complete, and accurate encounter data.

The questionnaire for LDH had similar domains; however, it focused on LDH’s data exchange with the MCEs.

HSAG created a different questionnaire for each MCE program (MCO, PAHP, PIHP) and submitted the appropriate questionnaire to each MCE to collect information. Additionally, since there were nine MCEs included in the study, HSAG distributed the questionnaire via an online tool to streamline collection of the responses.

- **Stage 3—Key Informant Interviews:** After reviewing responses to the questionnaires, HSAG followed up with key LDH and MCE information technology personnel to clarify any questions from the questionnaire responses.

## Administrative Profile

HSAG assessed final adjudicated encounters with service dates from January 1, 2023, through December 31, 2023. In addition, the EDV study used member demographic/enrollment data and provider data to evaluate the validity of key data elements in the encounter data. HSAG used the monthly data extracts submitted by LDH’s fiscal agent contractor (FAC) between January 2023 and December 2024 for the analysis.

Once HSAG received data files from LDH, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Percentage present—Required data fields were present on the file and had values in those fields.
- Percentage of valid values—The values were as expected (e.g., valid International Classification Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] codes in the diagnosis field).
- Referential integrity checks—Data sources could be joined with each other based on unique identifiers present in both data sources.

Once the final data were received and processed, HSAG conducted a series of analyses for five key metrics listed in the section below.

At a high level, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], 837 Dental [837D], and National Council for Prescription Drug Programs [NCPDP]). HSAG evaluated these metrics at the statewide level and by MCE. If results indicated data quality issue(s), HSAG conducted additional investigations to determine whether the issue was for a specific category of service (e.g., inpatient, nursing facilities), provider type (e.g., vision vendor, non-emergency transportation vendor), sub-population, etc. HSAG documented all noteworthy findings in the aggregate report.

### Metrics for Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur): If the number of members remained stable and there were no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month may indicate incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key was based on the *Member ID, Rendering Provider NPI, and Date of Service* values.
- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each MCE based on the member enrollment data extracted by LDH.
- Paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from a payment perspective.
- TPL paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from the TPL payment perspective.
- Percentage of duplicate encounters

### Metrics for Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by LDH within 360 days, from the payment date, in 30-day increments: This metric helps LDH to evaluate the extent to which the MCEs are in compliance with LDH's encounter data timeliness requirements (i.e., submit encounters within 30 days of adjudication).
- Claims lag triangle to illustrate the percentage of encounters received by LDH within two calendar months, three months, ..., and such from the service month: This metric allows LDH to evaluate how soon LDH may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Metrics for Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters are complete and accurate through the two study indicators described in Table 6-2 for the key data elements listed in Table 6-3. In addition, Table 6-3 shows the criteria HSAG used to evaluate the validity for each data element. These criteria are based on standard reference code sets, or referential integrity checks against member or provider data.

**Table 6-2—Study Indicators for Percent Present and Percent Valid**

Study Indicator	Denominator	Numerator
<b>Percent Present:</b> Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table 6-3 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.
<b>Percent Valid:</b> Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3. The criteria for validity are listed in Table 6-3.

**Table 6-3—Key Data Elements for Percent Present and Percent Valid**

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Member ID <sup>H</sup>	✓	✓	✓	✓	<ul style="list-style-type: none"> <li>In member file</li> <li>Enrolled in a specific MCE on the date of service</li> </ul>
Detail Service From Date <sup>D</sup>	✓	✓	✓		<ul style="list-style-type: none"> <li>Detail Service From Date ≤ Detail Service To Date</li> <li>Detail Service From Date ≤ Paid Date</li> </ul>
Detail Service To Date <sup>D</sup>	✓	✓	✓		<ul style="list-style-type: none"> <li>Detail Service To Date ≥ Detail Service From Date</li> <li>Detail Service To Date ≤ Paid Date</li> </ul>
Date of Service <sup>D</sup>				✓	<ul style="list-style-type: none"> <li>Date of Service ≤ Paid Date</li> </ul>

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Billing Provider NPI <sup>H</sup>	✓	✓	✓	✓	<ul style="list-style-type: none"> <li>In provider data when service occurred</li> <li>Meets Luhn formula requirements</li> </ul>
Rendering Provider NPI <sup>H</sup>	✓		✓		<ul style="list-style-type: none"> <li>In provider data when service occurred</li> <li>Meets Luhn check digit formula requirements</li> </ul>
Attending Provider NPI <sup>H</sup>		✓			<ul style="list-style-type: none"> <li>In provider data when service occurred</li> <li>Meets Luhn check digit formula requirements</li> </ul>
Referring Provider NPI <sup>H</sup>	✓	✓	✓		<ul style="list-style-type: none"> <li>In provider data when service occurred</li> <li>Meets Luhn check digit formula requirements</li> </ul>
Prescribing Provider NPI				✓	<ul style="list-style-type: none"> <li>In provider data when service occurred</li> <li>Meets Luhn check digit formula requirements</li> </ul>
Rendering Provider Taxonomy Code <sup>H</sup>	✓		✓		<ul style="list-style-type: none"> <li>In standard taxonomy code set</li> <li>Matches the value in provider data</li> </ul>
Attending Provider Taxonomy Code <sup>H</sup>		✓			<ul style="list-style-type: none"> <li>In standard taxonomy code set</li> <li>Matches the value in provider data</li> </ul>

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Primary Diagnosis Codes <sup>H</sup>	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year (e.g., in 2023 code set for services that occurred between October 1, 2022, and September 30, 2023)
Secondary Diagnosis Codes <sup>H</sup>	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Codes/Current Dental Terminology (CDT) Codes <sup>D</sup>	✓	✓	✓		In national CPT, HCPCS, CDT code sets for the correct code year (e.g., in 2023 code set for services that occurred in 2023)
Procedure Code Modifiers <sup>D</sup>	✓	✓			In national standard code set or in the origin and estimation modifier list <sup>10</sup>
Tooth Number <sup>D</sup>			✓		In national standard code set
Tooth Surface <sup>D</sup>			✓		In national standard code set
Oral Cavity Code <sup>D</sup>			✓		In national standard code set
Primary Surgical Procedure Codes <sup>H</sup>		✓			In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes <sup>H</sup>		✓			In national ICD-10-CM surgical procedure code sets for the correct code year

<sup>10</sup> Healthy Louisiana. Medicaid Managed Care Entities System Companion Guide, Version 1, June 18, 2025. Available at: [https://ldh.la.gov/assets/medicaid/MCE\\_System\\_Companion\\_Guide/HLA\\_MCE\\_SCG\\_v.1.pdf](https://ldh.la.gov/assets/medicaid/MCE_System_Companion_Guide/HLA_MCE_SCG_v.1.pdf). Accessed on: Dec 9, 2025.

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Revenue Codes <sup>D</sup>		✓			In national standard revenue code sets for the correct code year
Type of Bill Codes <sup>H</sup>		✓			In national standard type of code set
NDCs <sup>D</sup>	✓	✓		✓	In national NDC code sets
Submit Date <sup>D</sup>	✓	✓	✓	✓	MCE Submission Date (i.e., the date when the MCE submits encounters to LDH) ≥ MCE Paid Date
MCE Paid Date <sup>D</sup>	✓	✓	✓	✓	MCE Submission Date (i.e., the date when MCE submit encounters to LDH) ≥ MCE Paid Date
Detail Paid Amount <sup>D</sup>	✓	✓	✓	✓	Zero or positive
Detail TPL Paid Amount <sup>D</sup>	✓	✓	✓	✓	Zero or positive

<sup>H</sup> Conduct evaluation at the header level.

<sup>D</sup> Conduct evaluation at the detail level.

**Metrics for Encounter Data Referential Integrity**

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that were present in both the encounter data and member enrollment files) through the key study indicators described in Table 6-4. If an encounter contained more than one NPI (e.g., attending provider NPI and billing provider NPI on an institutional encounter), HSAG included both unique NPIs in the analysis.

**Table 6-4—Key Indicators of Referential Integrity**

Data Source	Indicator
Medical/Dental Encounters vs Member Enrollment	<ul style="list-style-type: none"> <li>Direction 1: Percentage of Members With a Medical/Dental Encounter Who Were Also in the Enrollment File</li> <li>Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter</li> </ul>

Data Source	Indicator
Pharmacy Encounters vs Member Enrollment	<ul style="list-style-type: none"> <li>• Direction 1: Percentage of Members With a Pharmacy Encounter Who Were Also in the Enrollment File</li> <li>• Direction 2: Percentage of Members in the Enrollment File With a Pharmacy Encounter</li> </ul>
Medical/Dental Encounters vs Pharmacy Encounters	<ul style="list-style-type: none"> <li>• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Also Have a Pharmacy Encounter</li> <li>• Direction 2: Percentage of Members With a Pharmacy Encounter Who Also Have a Medical/Dental Encounter</li> </ul>
Medical/Dental Encounters vs Provider File	<ul style="list-style-type: none"> <li>• Direction 1: Percentage of Providers in the Medical/Dental Encounter File Who Were Also in the Provider File</li> <li>• Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical/Dental Encounter File</li> </ul>
Pharmacy Encounters vs Provider File	<ul style="list-style-type: none"> <li>• Direction 1: Percentage of Providers in the Pharmacy Encounter File Who Were Also in the Provider File</li> <li>• Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File</li> </ul>

### Metrics for Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG used logic-based checks to ensure the encounter data appropriately support additional activities.

- Percentage of members with a medical encounter, pharmacy encounter, both medical and pharmacy encounters, or neither from January 1, 2023, through December 31, 2023.
- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provided insight into how well encounter data may be used to support future analyses, such as HEDIS performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

### Description of Data Obtained

#### Information Systems Review

Representatives from each MCE completed the LDH-approved questionnaire and then submitted their responses and relevant documents via the UST to HSAG for review. Of note, the questionnaire included an attestation statement for each MCE’s chief executive officer or responsible individual to certify that the information provided was complete and accurate.

## Administrative Profile

Data obtained from LDH included:

- Claims and encounter data with dates of service from January 1, 2023, through December 31, 2023.
- Member demographic and enrollment data.
- Provider data.

## How Data Were Aggregated and Analyzed

### Information Systems Review

Questionnaire responses were collected and stored in a secure database maintained by HSAG. HSAG compiled responses from the received LDH- and MCE-specific questionnaires and assembled the information in Microsoft Excel workbooks. Responses were analyzed based on their relationship to the IS review EDV measures.

### Administrative Profile

After consultation with LDH, HSAG used the data tables provided by LDH to create encounter, member demographic, member enrollment, and provider data files that contained the variables necessary for analysis. To analyze the data, HSAG prepared charts and figures to evaluate the pre-determined study metrics.

## How Conclusions Were Drawn

### Information Systems Review

HSAG made conclusions based on the CMS EQR Protocol 5, the MCE contracts, LDH's current encounter data submission requirements (e.g., companion guides), and HSAG's historical experience working with other states regarding the IS review.

### Administrative Profile

To draw conclusions about the quality of each MCE's encounter data submissions to LDH, HSAG evaluated the results based on the predefined study and/or key metrics described above. To identify strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the MCEs' encounter data submissions to LDH. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to LDH.

**Table 6-5—Assignment of EDV Measure Activities to the Quality, Timeliness, and Access Domains**

EDV Measure	Quality	Timeliness	Access
<i>IS Review: Encounter Data Sources and Systems</i>	✓	✓	
<i>IS Review: Payment Structures</i>	✓		
<i>IS Review: Encounter Data Quality Monitoring</i>	✓	✓	
<i>Administrative Profile: Encounter Data Completeness</i>	✓		
<i>Administrative Profile: Encounter Data Timeliness</i>		✓	
<i>Administrative Profile: Encounter Data Accuracy: Field-level Completeness and Accuracy</i>	✓		
<i>Administrative Profile: Encounter Data Referential Integrity</i>	✓		
<i>Administrative Profile: Encounter Data Logic</i>	✓		

## 7. Consumer Surveys: CAHPS-A and CAHPS-C

### Results

Table 7-1 presents ACLA’s 2023, 2024, and 2025 adult achievement scores.

**Table 7-1—Adult Achievement Scores**

Measure	2023	2024	2025
<i>Rating of Health Plan</i>	81.21%	76.47%	81.31%
<i>Rating of All Health Care</i>	82.30%	72.79%	78.95%
<i>Rating of Personal Doctor</i>	85.77%	82.82%	90.86% ▲ ↑
<i>Rating of Specialist Seen Most Often</i>	79.72%	NA	NA
<i>Getting Needed Care</i>	82.28%	79.75%	81.71%
<i>Getting Care Quickly</i>	86.39%	80.82%	84.60%
<i>How Well Doctors Communicate</i>	93.41%	94.19%	93.66%
<i>Customer Service</i>	95.76%	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 2025 score is statistically significantly higher than the 2025 NCQA national average.

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.

Table 7-2 presents ACLA’s 2023, 2024, and 2025 general child achievement scores.

**Table 7-2—General Child Achievement Scores**

Measure	2023	2024	2025
<i>Rating of Health Plan</i>	86.33%	85.96%	88.29%
<i>Rating of All Health Care</i>	86.57%	86.11%	89.81%
<i>Rating of Personal Doctor</i>	91.85%	91.95%	94.03% ↑
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Getting Needed Care</i>	86.29%	NA	86.03%
<i>Getting Care Quickly</i>	90.10%	NA	86.99% ▼
<i>How Well Doctors Communicate</i>	93.08%	93.62%	93.52%
<i>Customer Service</i>	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 2025 score is statistically significantly higher than the 2025 NCQA national average.

▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.

## MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- For the adult population, ACLA's 2025 achievement score was statistically significantly higher than the 2025 NCQA adult national average for one measure, *Rating of Personal Doctor*. **[Quality]**
- For the adult and general child populations, ACLA's 2025 achievement scores were statistically significantly higher than the 2024 achievement scores and the 2025 NCQA child national average, respectively, for one measure, *Rating of Personal Doctor*. **[Quality]**

For ACLA, the following opportunities for improvement were identified:

- For the adult population, ACLA's 2025 achievement scores were not statistically significantly lower than the 2025 NCQA adult national averages nor the 2024 achievement scores for any measure; therefore, no substantial weaknesses were identified. **[Quality, Timeliness, and Access]**
- For the general child population, ACLA's 2025 achievement score was statistically significantly lower than the 2024 achievement score for one measure, *Getting Care Quickly*. **[Quality and Timeliness]**

For ACLA, the following recommendation was identified:

- HSAG recommends that ACLA conduct root cause analyses or focus studies to identify factors contributing to lower member ratings for quality and timeliness of care. These efforts should include examining potential key demographic disparities within the population, such as race, ethnicity, age, or geographic location. Additionally, ACLA can assess clinical processes and implement targeted initiatives such as developing care reminders to encourage timely service requests from members. **[Quality and Timeliness]**

## 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

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 nonrespondents) 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 nonrespondents). 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 2025, 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.<sup>11</sup> 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."

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<sup>11</sup> For this report, the 2025 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 2025 NCQA CAHPS adult and general child Medicaid national averages.<sup>12</sup>

### **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 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.<sup>13</sup> 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 2025 achievement scores were compared to their corresponding 2024 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2025 achievement scores and the 2024 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2025 than 2024 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2025 than 2024 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 2025 NCQA national average was denoted with a black upward arrow (↑).<sup>14</sup> Conversely, an MCO that performed statistically significantly lower than the 2025 NCQA national average was denoted with

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<sup>12</sup> National data were obtained from NCQA's 2025 Quality Compass.

<sup>13</sup> 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.

<sup>14</sup> National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2025*. Washington, DC: NCQA, September 2025.

a black downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2025 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 2025 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 7-3.

**Table 7-3—Assignment of CAHPS Survey Measure Activities to the Quality, Timeliness, and Access Domains**

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

## 8. Behavioral Health Member Satisfaction Survey

### Results

Table 8-1 presents the 2023, 2024, and 2025 adult achievement scores for ACLA and the Healthy Louisiana SWA.

**Table 8-1—Adult Achievement Scores for ACLA**

Measure	2023	2024	2025	Healthy Louisiana SWA
<i>Rating of Health Plan</i>	58.93%	54.14%	60.28%	57.88%
<i>How Well People Communicate</i>	92.44%	91.36%	92.13%	91.16%
<i>Cultural Competency</i>	90.00% <sup>+</sup>	91.67% <sup>+</sup>	88.89% <sup>+</sup>	86.01% <sup>+</sup>
<i>Helped by Counseling or Treatment</i>	73.65%	74.84%	73.24%	70.38%
<i>Treatment or Counseling Convenience</i>	90.42%	89.87%	90.21%	88.13%
<i>Getting Needed Treatment</i>	81.33%	80.77%	82.86%	81.75%
<i>Help Finding Counseling or Treatment</i>	34.38% <sup>+</sup>	73.53% <sup>+</sup>	57.89% <sup>+</sup>	50.82%
<i>Customer Service</i>	73.08% <sup>+</sup>	71.43% <sup>+</sup>	71.43% <sup>+</sup>	70.81%
<i>Helped by Crisis Response Services</i>	78.57% <sup>+</sup>	80.00% <sup>+</sup>	82.35% <sup>+</sup>	72.26%

*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.*

Table 8-2 presents the 2023, 2024, and 2025 child achievement scores for ACLA and the Healthy Louisiana SWA.

**Table 8-2—Child Achievement Scores for ACLA**

Measure	2023	2024	2025	Healthy Louisiana SWA
<i>Rating of Health Plan</i>	64.29% <sup>+</sup>	59.48%	57.69% <sup>↓</sup>	63.63%
<i>How Well People Communicate</i>	93.49% <sup>+</sup>	92.13%	89.88%	91.03%
<i>Cultural Competency</i>	100.00% <sup>+</sup>	100.00% <sup>+</sup>	75.00% <sup>+</sup>	92.57% <sup>+</sup>
<i>Helped by Counseling or Treatment</i>	70.83% <sup>+</sup>	60.68%	60.00%	61.01%
<i>Treatment or Counseling Convenience</i>	91.67% <sup>+</sup>	87.93%	91.35%	88.86%
<i>Getting Needed Treatment</i>	85.92% <sup>+</sup>	79.13%	77.88%	78.93%
<i>Help Finding Counseling or Treatment</i>	30.77% <sup>+</sup>	47.83% <sup>+</sup>	42.86% <sup>+</sup>	38.57% <sup>+</sup>
<i>Customer Service</i>	71.43% <sup>+</sup>	75.00% <sup>+</sup>	63.64% <sup>+</sup>	71.71% <sup>+</sup>
<i>Getting Professional Help</i>	87.14% <sup>+</sup>	89.66%	82.86%	87.75%
<i>Help to Manage Condition</i>	91.55% <sup>+</sup>	81.20%	81.73%	83.38%

*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 2025 score is statistically significantly lower than the 2025 Healthy Louisiana SWA.*

## MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strength was identified:

- For the adult and child populations, ACLA’s 2025 achievement scores were not statistically significantly higher than the 2024 achievement scores or Healthy Louisiana SWA for any measure; therefore, no substantial strengths were identified. **[Quality, Timeliness, and Access]**

For ACLA, the following opportunities for improvement were identified:

- For the adult population, ACLA’s 2025 achievement scores were not statistically significantly lower than the 2024 achievement scores or Healthy Louisiana SWA for any measure; therefore, no substantial opportunities for improvement were identified. **[Quality]**
- For the child population, ACLA’s 2025 achievement score for *Rating of Health Plan* was statistically significantly lower than the 2025 Healthy Louisiana SWA. **[Quality]**

For ACLA, the following recommendation was identified:

- HSAG recommends that ACLA focus on improving members’ overall experiences with their health plan by performing a root cause analysis, which could determine if there are any outliers within the data so that ACLA can identify the primary areas of focus and develop appropriate strategies to improve performance. ACLA could include CAHPS results to providers and send reminders about the importance of handling challenging patient encounters. Additionally, ACLA should emphasize patient-centered communication for the MCO members. **[Quality]**

## Methodology

### Objectives

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

### Technical Methods of Data Collection

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 2025.

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 2025 achievement scores were compared to their corresponding 2024 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2025 achievement scores and the 2024 achievement scores are noted with directional triangles. An MCO’s score that performed statistically significantly higher in 2025 than 2024 is noted with a black upward triangle (▲). An MCO’s score that performed statistically significantly lower in 2025 than 2024 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 accessibility of 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 8-3.

**Table 8-3—Assignment of Behavioral Health Member Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains**

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

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

## 9. Case Management Performance Evaluation

### Results

During SFY 2025, HSAG conducted a review of the MCO's actions to address CAP findings, as identified during the SFY 2024 reviews. In addition, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the SFY 2026 CMPE.

The MCO successfully completed remediation actions to address the CAP findings, and the CAP was closed in October 2024.

HSAG will assess the MCO's implementation of remediation actions during the SFY 2026 reviews.

### MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strength was identified:

- The MCO successfully completed remediation actions to address the CAP findings. **[Quality]**

For ACLA, the following opportunity for improvement was identified:

- The MCO demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. **[Timeliness]**

For ACLA, the following recommendation was identified:

- The MCO must continue the efforts documented in its CAP responses to ensure compliance with contractual requirements. **[Quality]**

## 10. Quality Rating System

### Results

The 2025 (CY 2024) QRS results for ACLA are displayed in Table 10-1.

**Table 10-1—2025 (CY 2024) QRS Results for ACLA**

Composites and Subcomposites	Star Rating
<b>Overall Rating*</b>	<b>4.0</b>
<b>Patient Experience</b>	<b>4.0</b>
Getting Care	3.5
Satisfaction with Plan Physicians	5.0
Satisfaction with Plan and Plan Services	4.5
<b>Prevention and Equity</b>	<b>3.5</b>
Children and Adolescent Well-Care	3.0
Women’s Reproductive Health	2.5
Cancer Screening	3.5
Equity	5.0
Other Preventive Services	4.0
<b>Treatment</b>	<b>3.5</b>
Respiratory	2.5
Diabetes	4.5
Heart Disease	3.0
Behavioral Health—Care Coordination	2.5
Behavioral Health—Medication Adherence	3.0
Behavioral Health—Access, Monitoring, and Safety	3.5
Reduce Low Value Care	3.0

\*This rating includes all measures in the 2025 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.

Please note that HSAG removed the *Plan All-Cause Readmissions* (PCR) measure and the Risk-Adjusted Utilization subcomposite from the 2025 report card analysis because NCQA recommended a break in trending so comparisons to the national average could not be performed.

ACLA earned an Overall Rating of 4.0 stars, with 4.0 stars for the Patient Experience composite, 3.5 stars for the Prevention and Equity composite, and 3.5 stars for the Treatment composite.

## MCO Strengths, Opportunities for Improvement, and Recommendations

For ACLA, the following strengths were identified:

- For the Patient Experience composite, ACLA earned 5.0 stars and 4.5 stars for the Satisfaction with Plan Physicians and Satisfaction with Plan and Plan Services subcomposites, respectively. Both subcomposites are based on ACLA member responses to CAHPS survey questions, demonstrating ACLA members are satisfied with their providers and their health plan and the services it provides. **[Quality]**
- For the Prevention and Equity composite, ACLA earned 5.0 stars for the Equity subcomposite, demonstrating strength for ACLA related to collecting language preferences and race/ethnicity information from its members. ACLA also earned 4.0 stars for the Other Preventive Services subcomposite, demonstrating strength for ACLA related to providing chlamydia screenings for young women. **[Quality and Access]**
- For the Treatment composite, ACLA earned 4.5 stars for the Diabetes subcomposite, demonstrating strength for ACLA related to diabetic care. **[Quality and Access]**

For ACLA, the following opportunities for improvement were identified:

- For the Prevention and Equity composite, ACLA earned 2.5 stars for the Women’s Reproductive Health subcomposite, demonstrating opportunities for improvement for ACLA related to women receiving timely prenatal and postpartum care. **[Quality, Timeliness, and Access]**
- For the Treatment composite, ACLA earned 2.5 stars for the Respiratory and Behavioral Health—Care Coordination subcomposites, demonstrating opportunities for improvement for ACLA related to antibiotic use for bronchitis/bronchiolitis and ensuring members receive timely follow up after hospitalizations and ED visits for behavioral health conditions. **[Quality, Timeliness, and Access]**

For ACLA, the following recommendation was identified:

- The MCEs were directed to reference the recommendations made for PMV and CAHPS as the Health Plan Report Card reflects HEDIS and CAHPS results. HSAG did not make additional recommendations specific to the QRS activity.

## Methodology

### Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the six Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, HUM, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. The 2025 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 2024 CAHPS member-level data files and HEDIS IDSS data files from LDH and the six MCOs. The *HEDIS MY 2024 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2024 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 2024 (MY 2023) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.<sup>15</sup>

### 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 2025 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:<sup>16,17</sup>

- Overall
- Patient Experience
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan and Plan Services

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<sup>15</sup> 2024 (MY 2023) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by August 5, 2025, and 2025 (MY 2024) Quality Compass national Medicaid ALOB benchmarks were not available until August 29, 2025.

<sup>16</sup> NCQA. 2025 Health Plan Ratings Required HEDIS, CAHPS, and HOS Measures. Available at: [https://wpcdn.ncqa.org/www-prod/2025-HPR-List-of-Required-Performance-Measures\\_April-2025-Update.pdf](https://wpcdn.ncqa.org/www-prod/2025-HPR-List-of-Required-Performance-Measures_April-2025-Update.pdf). Accessed on: Dec 9, 2025.

<sup>17</sup> Please note that eight measures from NCQA's Health Plan Ratings measure list were not included in the 2025 report card measure list given that the MCOs are not required to report them for MY 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 2025 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2024 (MY 2023) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 10-2. For the *Race/Ethnicity Diversity of Membership*, *Language Diversity of Membership*, and *Plan All-Cause Readmissions* measures, HSAG followed NCQA’s methodology for scoring race/ethnicity diversity measures, language diversity measures, and risk-adjusted utilization measures, respectively.

**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:

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

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 2025 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 2025 to comprehensively assess ACLA’s performance in providing quality, timely, and accessible healthcare services to Louisiana’s Medicaid and CHIP members. HSAG provides ACLA’s strengths, opportunities for improvement, and recommendations in Table 11-1 through Table 11-3.

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

Overall MCO Strengths	
<b>PIP</b>	<ul style="list-style-type: none"> <li>For all four PIPs assessed for achieving significant improvement, at least some of ACLA’s reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. <b>[Quality, Timeliness, and Access]</b></li> </ul>
<b>PMV</b>	<ul style="list-style-type: none"> <li>ACLA was effective in coordinating with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, initiate treatment for members with a new SUD episode, and engage these members in subsequent SUD services or medications. <b>[Quality, Timeliness, and Access]</b></li> <li>ACLA members received screenings for cervical cancer, colorectal cancer, and chlamydia at rates above the NCQA national 50th percentile benchmark. <b>[Quality, Timeliness, and Access]</b></li> </ul>
<b>Compliance</b>	<ul style="list-style-type: none"> <li>ACLA scored 100 percent for seven standards in the CR, indicating that ACLA’s policies and procedures were generally compliant with contract requirements and ACLA staff were generally knowledgeable about the requirements, policies, and procedures. <b>[Quality]</b></li> </ul>
<b>NAV</b>	<ul style="list-style-type: none"> <li>Overall, 96.3 percent of respondents in the provider access survey confirmed the sampled address was correct. <b>[Quality and Access]</b></li> <li>ACLA demonstrated strong provider data validation and engagement practices by conducting weekly on-site visits to verify demographic and access information and provide ongoing education, and monthly secret shopper outreach calls to confirm appointment availability and after-hours access. <b>[Quality and Access]</b></li> </ul>
<b>EDV</b>	<ul style="list-style-type: none"> <li>ACLA reported less than 1.0 percent of institutional, pharmacy, and NEMT encounters as initially rejected and not yet accepted; had low duplicate rates for professional, institutional, and pharmacy encounters; and had all key data elements populated with at least 95.0 percent of valid values for institutional and pharmacy encounters. <b>[Quality]</b></li> <li>ACLA submitted 98.2 percent of professional encounters and 99.4 percent of pharmacy encounters within 60 days from the payment date. <b>[Timeliness]</b></li> </ul>

Overall MCO Strengths	
CAHPS and Behavioral Health Member Satisfaction Survey	<ul style="list-style-type: none"> <li>For the <i>Rating of Personal Doctor</i> CAHPS measure, ACLA’s 2025 CAHPS achievement score was statistically significantly higher than the 2025 NCQA national average for the adult population and was statistically significantly higher than the 2024 achievement scores and the 2025 NCQA child national average for the adult and general child populations. <b>[Quality]</b></li> <li>For the Behavioral Health Member Satisfaction Survey, no notable strengths were identified. <b>[Quality]</b></li> </ul>
CMPE	<ul style="list-style-type: none"> <li>The MCO successfully completed remediation actions to address the CAP findings. <b>[Quality]</b></li> </ul>

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

Overall MCO Opportunities for Improvement	
PIP	<ul style="list-style-type: none"> <li>ACLA did not achieve significant improvement outcomes for all PIPs. <b>[Quality]</b></li> </ul>
PMV	<ul style="list-style-type: none"> <li>ACLA had room for improvement to ensure that members hospitalized or accessing the ED for mental illness receive adequate follow-up care. <b>[Quality, Timeliness, and Access]</b></li> <li>ACLA had room for improvement in ensuring that providers effectively prevent or minimize the prescribing of antibiotics to children with URIs and adults with bronchitis or bronchiolitis. <b>[Quality]</b></li> </ul>
Compliance	<ul style="list-style-type: none"> <li>ACLA demonstrated several opportunities to improve compliance with member information requirements, including inclusion of required information in member materials, complying with criteria related to taglines and requesting auxiliary aids, member notification of terminated providers, and delivery of the member handbook. <b>[Quality]</b></li> <li>ACLA’s paper and electronic provider directory were missing required components, and its website did not inform members of availability of materials in paper form. <b>[Quality]</b></li> <li>ACLA did not monitor its provider network to ensure adequate access to all services; require network providers to meet State standards for timely access; ensure its network providers offer required hours of operation; or ensure its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members. <b>[Quality and Access]</b></li> <li>ACLA did not conduct an initial screening of each member’s needs within 90 calendar days of the effective date of enrollment for all new members. <b>[Quality and Timeliness]</b></li> <li>ACLA did not demonstrate compliance with several requirements related to credentialing and recredentialing. <b>[Quality]</b></li> <li>ACLA did not ensure all its delegation agreements complied with all requirements. <b>[Quality]</b></li> </ul>

Overall MCO Opportunities for Improvement	
	<ul style="list-style-type: none"> <li>• ACLA did not ensure that all grievance and appeal resolution letters meet the state-required reading grade level. <b>[Quality]</b></li> </ul>
NAV	<ul style="list-style-type: none"> <li>• Acceptance of ACLA was inaccurate with 72.5 percent of providers in the PDV and 71.3 percent of locations in the provider access survey accepting ACLA. <b>[Quality and Access]</b></li> <li>• Compliance scores varied by survey type with an overall compliance score of 52.3 percent for the PDV and 58.5 percent for the provider access survey. <b>[Quality and Access]</b></li> </ul>
EDV	<ul style="list-style-type: none"> <li>• ACLA did not report performing claim volume and timeliness checks on encounters collected by the MCE; had no dental encounters with dates of service in 2023 in LDH’s data warehouse; and had some data elements with less than 95 percent of valid values. <b>[Quality and Timeliness]</b></li> </ul>
CAHPS and Behavioral Health Member Satisfaction Survey	<ul style="list-style-type: none"> <li>• For the general child population, ACLA’s 2025 CAHPS achievement score was statistically significantly lower than the 2024 achievement score for one measure, <i>Getting Care Quickly</i>. <b>[Quality and Timeliness]</b></li> <li>• For the child population in the Behavioral Health Member Satisfaction Survey, ACLA’s 2025 achievement score for <i>Rating of Health Plan</i> was statistically significantly lower than the 2025 Healthy Louisiana SWA. <b>[Quality]</b></li> </ul>
CMPE	<ul style="list-style-type: none"> <li>• ACLA demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. <b>[Timeliness]</b></li> </ul>

**Table 11-3—Recommendations**

Overall MCO Recommendations		
EQR Activity	Recommendation	Associated Quality Strategy Goals to Target for Improvement
PIP	<ul style="list-style-type: none"> <li>• To facilitate significant outcomes improvement for all PIPs, ACLA should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. ACLA should also revisit barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. <b>[Quality]</b></li> </ul>	Goal 4: Promote wellness and prevention
PMV	<ul style="list-style-type: none"> <li>• ACLA should work with providers to identify barriers and improve</li> </ul>	Goal 2: Improve coordination and transitions of care

Overall MCO Recommendations		
	<p>coordination of follow-up care following discharge from the hospital or ED for members with mental illness and substance use. <b>[Quality, Timeliness, and Access]</b></p>	
PMV	<ul style="list-style-type: none"> <li>• ACLA should work with providers to prevent or reduce antibiotic dispensing to treat URIs in children and adults with bronchitis or bronchiolitis. <b>[Quality]</b></li> </ul>	Goal 4: Promote wellness and prevention
Compliance	<ul style="list-style-type: none"> <li>• ACLA must include required information in its member-related materials, ensure member materials are available in prevalent non-English languages and comply with criteria related to taglines and requesting auxiliary aids, give written notice of termination of providers to members within required time frames, and ensure delivery of the member handbook within a reasonable time. <b>[Quality]</b></li> <li>• ACLA must include required components in its paper and electronic provider directory and inform members of the availability of materials in paper form. <b>[Quality and Access]</b></li> <li>• ACLA must monitor its provider network to ensure adequate access, require network providers to meet State standards for timely access, ensure its network providers offer required hours of operation, and ensure its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members. <b>[Quality and Access]</b></li> <li>• ACLA must conduct an initial screening of each member’s needs within 90 calendar days of the effective date of enrollment for all</li> </ul>	<p>Goal 1: Ensure access to care to meet enrollee needs</p> <p>Goal 2: Improve coordination and transitions of care</p> <p>Goal 3: Facilitate patient-centered, whole-person care</p> <p>Goal 7: Pay for value and incentivize innovation</p>

Overall MCO Recommendations		
	<p>new members. <b>[Quality and Timeliness]</b></p> <ul style="list-style-type: none"> <li>• ACLA must ensure its policies, procedures, and processes for credentialing and recredentialing comply with federal and State requirements. <b>[Quality]</b></li> <li>• ACLA must ensure all its delegation agreements comply with all requirements. <b>[Quality]</b></li> <li>• ACLA must ensure that all grievance and appeal resolution letters meet the state-required reading grade level. <b>[Quality]</b></li> <li>• ACLA must complete its CAP to resolve all <i>Not Met</i> findings from the CR.</li> </ul>	
<b>NAV</b>	<ul style="list-style-type: none"> <li>• ACLA should consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care timely. <b>[Timeliness and Access]</b></li> <li>• ACLA should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active providers, telephone number, new patient acceptance). LDH could consider developing time frames and monitoring procedures (e.g., provider portals, data submissions) for ACLA to confirm office outreach and provider information. <b>[Quality and Access]</b></li> </ul>	<p>Goal 1: Ensure access to care to meet enrollee needs</p>
<b>EDV</b>	<ul style="list-style-type: none"> <li>• ACLA should build additional encounter data quality monitoring reports to evaluate encounter data completeness and timeliness. <b>[Quality and Timeliness]</b></li> <li>• ACLA should work with LDH to determine whether ACLA had dental</li> </ul>	<p>Goal 7: Pay for value and incentivize innovation</p> <p>Goal 8: Minimize wasteful spending</p>

Overall MCO Recommendations		
	<p>encounters with dates of service in 2023 that should be submitted to LDH. <b>[Quality]</b></p> <ul style="list-style-type: none"> <li>• ACLA should investigate the root causes for the data element with less than 95.0 percent of valid values to improve accuracy. <b>[Quality]</b></li> </ul>	
<p><b>CAHPS and Behavioral Health Member Satisfaction Survey</b></p>	<ul style="list-style-type: none"> <li>• ACLA should conduct root cause analyses or focus studies to identify factors contributing to lower child member CAHPS ratings for quality and timeliness of care. <b>[Quality]</b></li> <li>• For the Behavioral Health Member Satisfaction Survey, ACLA should focus on improving members’ overall experiences with their health plan by performing a root cause analysis, which could determine if there are any outliers within the data so that ACLA can identify the primary areas of focus and develop appropriate strategies to improve performance. <b>[Quality and Timeliness]</b></li> </ul>	<p>Goal 3: Facilitate patient-centered, whole-person care</p>
<p><b>CMPE</b></p>	<ul style="list-style-type: none"> <li>• ACLA should continue the efforts documented in its CAP responses to ensure compliance with contractual requirements, including those related to ongoing scheduled CM activities. <b>[Quality]</b></li> </ul>	<p>Goal 2: Improve coordination and transitions of care</p>

## 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 2023–2024 recommendations. Table 12-1 through Table 12-9 contain a summary of the follow-up actions that ACLA completed in response to the EQRO’s SFY 2024 recommendations. Furthermore, HSAG assessed ACLA’s approach to addressing the recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

### EQRO’s Scoring Assessment

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

*High* indicates *all* of the following:

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

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



*Medium* indicates one or more of the following:

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

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



Low indicates one or more the following:

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

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



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

Recommendation
To facilitate significant outcomes improvement for all PIPs, HSAG recommended that ACLA review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. ACLA should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed through new or revised interventions to drive outcomes improvement.
Response
<p><b>Describe initiatives implemented based on recommendations:</b></p> <ul style="list-style-type: none"> <li>• Intervention Evaluation: Ongoing quarterly tracking of intervention performance, supported by cross-functional workgroup meetings to review progress and identify improvement opportunities.</li> <li>• Barrier Reassessment: Annual updates to each PIP’s barrier analysis, including refreshed root cause analyses and quarterly discussion within interdepartmental workgroups to ensure barriers are actively monitored and addressed.</li> <li>• Impact Assessment: Evaluation of intervention performance using return on investment and outcome data.</li> <li>• Resource Allocation: Strategic shifts of funding and staff support away from low-yield activities toward high-impact initiatives.</li> <li>• Intervention Expansion: Scaling up proven strategies that demonstrate measurable improvements in member outcomes and program efficiency.</li> <li>• New Intervention Design: Develop and pilot innovative approaches based on data trends, member feedback, provider feedback and associate feedback.</li> <li>• Population-Specific Tailoring: Refining interventions to align with the characteristics and needs of standout population identified through stratified data analysis.</li> </ul> <p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b></p> <ul style="list-style-type: none"> <li>• Provider outreach and education efforts continue and now OB/GYNs. As of October 31, 2025, 146 Group IDs have been engaged. Of the 146 providers engaged, 3 were OB/GYN specialists who were educated utilizing the newly developed OB/GYN Quality Provider training.</li> <li>• The implementation of the new pilot for Behavioral Health Member Advisory Council (MAC) is planned for November 2025.</li> </ul>

- Published in June this year, the Cancer Screening Toolkit has been consistently leveraged in provider outreach and education activities. Since publication, the overall cervical cancer screening rate has increased from 50.18% in June 2025 to the current rate ending September 2025 of 53.99%.
- Partnered with 12 Head Start Centers and a provider willing to perform Fluoride Varnish Application at the centers in 2024. Due to the success was also planned for 2025. In 2024, 336 children received fluoride varnish applications. Of the 336 fluoride applications, 56 were ACLA plan members. In 2025, the plan increased the Head Start Centers partnering from 12 sites to 14 sites. ACLA is currently awaiting data from the 2025 participation.
- A new disparity was identified within the cervical cancer screening age group of 40–64-year-olds, who received a targeted mailer. Of those who received a mailer, 8.97% became compliant with the screening.
- A modification to the Case Management (CM) referral process has significantly boosted Community Health Navigator (CHN) outreach success, with successful outreach increasing from 43.35% at the close of Q1 2025 to 93.24% by the end of Q3 2025.
- New vendor/platform for text messages, offering members an enhanced way to interact with messages from the plan. Since the change, member engagement with text messages has increased. The number of members from a mental health hospital discharge who attended a visit with a qualifying provider within 30 days who received a BH text message increased from 27.46% at the end of Q3 2024 to 38.75% in Q3 of 2025.
- The plan developed and published an STI screening toolkit designed for provider use in May 2024. In 2025 there has been active promotion during provider interactions. Since its active promotion, the number of members who received provider education for HIV screening increased from 63.67% ending Q3 2024, to 66.24% ending Q3 2025. Also, there was a positive change in HIV screened persons aged 15-65 years old without a diagnosis of HIV infection from 9.27% at beginning of 2025 to the current 10.15%. Persons screened for HIV among pregnant persons with encounters for labor and delivery increased from 66.29% at the beginning of 2025 to 68.11% currently, demonstrating positive impact.
- In 2025, the plan intensified its notification of pregnancy efforts through enhanced provider alerts, support from the Provider Network Management team and targeted outreach and education led by the Quality team. These coordinated efforts resulted in substantial increase in notification of pregnancy, with the percentage identified rising from 7.35% at the end of Q2 2024 to 24.52% by Q2 2025.
- Provider outreach and education efforts emphasizing the importance of timely syphilis screening during pregnancy, alongside promotion of the STI screening toolkit, have expanded significantly. The promotion of providers increased from 1.22% at the end of Q3 2024 to 2.39% by Q3 2025.

**Identify any barriers to implementing initiatives:**

- Resource limitations
- Competing priorities
- Member engagement challenges
- Communication gaps such as coordination between providers/facilities/MCOs regarding discharge that can delay follow up
- Provider schedules, availability

**Identify strategy for continued improvement or overcoming identified barriers:**


- Review data to allocate resources
- Leverage interdepartmental workgroup to streamline efforts and reduce duplication across teams
- Automate low value tasks to free up capacity for other activities
- Expand text messages, phone outreach and provider education to reach members through preferred channels

- Strengthen communication pathways between providers, facilities and the MCO to ensure timely and accurate discharge planning, establishing regular touchpoints with providers
- Encourage extended hours and telehealth options to accommodate provider and member availability
- Offer streamlined documentation to reduce administrative burden


**HSAG Assessment**






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

Recommendation
HSAG recommended that ACLA evaluate performance measures with rates below the NCQA national 50th percentile.
Response
<p><b>Describe initiatives implemented based on recommendations:</b></p> <ul style="list-style-type: none"> <li>• Incentivize both members and providers for care gap closure</li> <li>• Connect with both members and providers via use of a coordinated, personalized, and data-driven strategy that leverages various channels like website content, email, social media, phone, and events, while maintaining a consistent message</li> <li>• Integrate telehealth and community-based services through strategic partnerships to deliver accessible care where our members live and work</li> <li>• Execute quality provider visits that can be leveraged to:               <ul style="list-style-type: none"> <li>○ understand performance measures and set up real-time ADT event notifications that, once enabled, provide an immediate email notification of a patient's discharge status</li> <li>○ learn the provider portal to better access reports and resources for practice improvement</li> </ul> </li> </ul>
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b> A substantial portion of the 94 measures have demonstrated improvement.</p>
<p><b>Identify any barriers to implementing initiatives:</b></p> <ul style="list-style-type: none"> <li>• High unable to contact member rates</li> <li>• Providers report high workload demands, time constraints, and reduced staff</li> <li>• Providers report high volumes of unreached members</li> </ul>
<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b></p> <ul style="list-style-type: none"> <li>• Implement targeted provider outreach for admissions and education</li> <li>• Continue and expand virtual care partnerships</li> <li>• Drive provider action on follow-ups by rewarding patient engagement</li> <li>• Continue targeted outreach to providers with high/low utilization by measure</li> </ul>
HSAG Assessment


Recommendation
<p>To improve performance on the <i>Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge and Within 30 Days of Discharge</i>, <i>Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge and Within 30 Days of Discharge</i>, and <i>Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and Within 30 Days of Discharge</i> measure indicators, HSAG recommended that the MCOs work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and the MCOs.</p>
Response
<p><b>Describe initiatives implemented based on recommendations:</b></p> <ul style="list-style-type: none"> <li>• Quality provider visits to review measure specifications, identify barriers.</li> <li>• Leverage real-time Admission, Discharge, and Transfer (ADT) alerts for timely patient follow-up</li> <li>• Inpatient admission education and support for providers</li> <li>• Proactively analyze claims and encounter data to identify and prevent missed follow-ups</li> <li>• Embed Community Health Navigators (CHN) in high-traffic facilities for smoother discharge</li> <li>• Leverage Transitions of Care Case Managers (TOC CM) to enhance post-discharge outcomes</li> <li>• Reducing readmission risks and improving outcomes through a text message-based follow-up initiative</li> <li>• Partner with telehealth providers to complete timely post-discharge visits for members, ensuring smooth transitions of care</li> <li>• Provider incentive program includes a component directly tied to these measures: Follow-Up After Hospitalization for Mental Illness (FUH) 7 days and 30 days, Follow-Up After Emergency Department for Mental Illness (FUM) 7 days and 30 days, and Follow-Up After Emergency Visit for Substance Use (FUA) 7 days and 30 days.</li> <li>• Provider incentive program also addresses potentially preventable events</li> </ul>
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b></p> <ul style="list-style-type: none"> <li>• Providers can leverage quality visits to understand performance measures and set up real-time ADT event notifications that, once enabled, provide an immediate email notification of a patient's discharge status.</li> <li>• Achieved 80% outreach and education rate among applicable providers regarding member inpatient admissions in Q3 2025</li> <li>• Weekend discharges had the lowest 7-day follow-up rates. ACLA adjusted the process to prioritize outreach and scheduling for these members on Monday mornings.</li> <li>• CHN team engaged 93.24% of Q3 2025 mental health hospital discharge cohort in FUH population. Among those engaged by a CHN, 38.93% had a documented qualifying follow-up appointment within 30 days post-discharge.</li> <li>• Following transition to new text vendor, member engagement significantly improved, as evidenced by a substantial increase in follow-up rate for members discharged from mental health hospitals. The number of members attending a visit with a qualifying provider within 30 days rose by 11.29% in one year.</li> <li>• One key partnership, established to improve care coordination and streamline member access to behavioral health providers, has successfully facilitated 2,740 inpatient and 107 emergency department discharge referrals since January 2025.</li> </ul>

<ul style="list-style-type: none"> <li>Fifty-seven provider groups qualified for the Behavioral Health Provider Incentive Program, with a goal of expanding participation in future payout cycles.</li> </ul>
<p><b>Identify any barriers to implementing initiatives:</b></p> <ul style="list-style-type: none"> <li>Provider schedules and availability</li> <li>Providers report high volumes of unreached members</li> <li>Challenges in interdepartmental coordination between inpatient and emergency department teams</li> <li>Low adoption rate among providers for utilizing portal to access discharge data and a lack of enrollment for real-time ADT alerts</li> </ul>
<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b></p> <ul style="list-style-type: none"> <li>Implement targeted provider outreach for admissions and education</li> <li>Continue and expand virtual care partnerships</li> <li>Drive provider action on follow-ups by rewarding patient engagement</li> <li>Ensure long-term success of CHN initiative</li> </ul>
<p><b>HSAG Assessment</b></p> 
<p><b>Recommendation</b></p> <p>To improve performance on the Plan <i>All-Cause Readmissions—O/E Ratio</i> measure, HSAG recommended that the MCOs work with providers to improve post-discharge planning and care coordination.</p>
<p><b>Response</b></p> <p><b>Describe initiatives implemented based on recommendations:</b>          ACLA issued a Provider Alert to emphasize the significance of the Plan All-Cause Readmissions (PCR) measure and effective strategies for readmission prevention. Key actions include:</p> <ul style="list-style-type: none"> <li>Leveraging real-time ADT alerts for timely patient follow-up and facilitating member referrals to our comprehensive Transition of Care Case Management Program</li> <li>Providers receive targeted education on key quality measures during scheduled Quality Provider visits</li> <li>Data-driven alerts are distributed via fax to provider groups identified as having high readmission rates</li> <li>Account Executives utilize alerts as basis for direct, 1:1 education with providers during field visits to ensure awareness and promote improvement initiatives</li> <li>Regional community and quality roundtable workgroups convene monthly to identify providers with high readmission rates, address systemic barriers and coordinate effective interventions</li> <li>A component of the provider incentive program is specifically designed to address potentially preventable readmissions</li> </ul>
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b>          Improved performance has yet to be demonstrated.</p>
<p><b>Identify any barriers to implementing initiatives:</b></p> <ul style="list-style-type: none"> <li>Providers with limited time to discuss quality measures</li> <li>Low adoption rate among providers for utilizing portal to access discharge data and a lack of enrollment for real-time ADT alerts</li> <li>Providers report members not following up after d/c or not following discharge instructions</li> </ul>

<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b> Targeted outreach to providers with high readmissions will continue in 2026</p>
<p><b>HSAG Assessment</b></p>

<p><b>Recommendation</b></p>
<p>To improve performance on the Use of <i>Imaging Studies for Low Back Pain</i> measure, HSAG recommended that the MCOs focus their efforts on decreasing unnecessary imaging for low back pain. HSAG also recommended that the MCOs work with providers to trial solutions to reduce the inappropriate ordering of imaging studies.</p>
<p><b>Response</b></p>
<p><b>Describe initiatives implemented based on recommendations:</b> ACLA issued a Provider Alert to emphasize the significance of the Use of Imaging Studies for Low Back Pain (LBP) measure and effective strategies for reducing unnecessary imaging for low back pain. Key actions include:</p> <ul style="list-style-type: none"> <li>• Sourcing HEDIS® LBP technical specification measure exclusions and assessing patients' low back pain through physical examination to identify secondary causes before recommending an imaging study</li> </ul>
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b> Improved performance has yet to be demonstrated.</p>
<p><b>Identify any barriers to implementing initiatives:</b> There is a risk that these guidelines could be perceived as undermining the providers' expertise or micromanaging their approach to patient treatment.</p>
<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b></p> <ul style="list-style-type: none"> <li>• Advance quality-focused care by partnering with a value-based care organization to ensure adherence to evidence-based imaging guidelines for acute LBP</li> <li>• Prioritize effective communication of LBP clinical practice guideline changes to providers</li> </ul>
<p><b>HSAG Assessment</b></p>

<p><b>Recommendation</b></p>
<p>To improve performance on the <i>Non-Recommended Cervical Screening in Adolescent Females</i> measure, HSAG recommended that the MCOs work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females.</p>
<p><b>Response</b></p>
<p><b>Describe initiatives implemented based on recommendations:</b></p> <ul style="list-style-type: none"> <li>• High-volume providers were educated on Cervical Cancer Screening (CCS) measure guidelines.</li> <li>• Provider alerts, newsletters, and a Cancer Screening Toolkit were published on ACLA's website</li> <li>• Members were outreached and educated on Cervical Cancer Screening guidelines via live telephonic outreach, social media posts, text campaigns, mailers, and community events.</li> </ul>



<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b>          The <i>Non-Recommended Cervical Screening in Adolescent Females</i> measure was retired in 2024; therefore, data is no longer available. Current year-to-date performance for the <i>Cervical Cancer Screening</i> measure is 3.04 percentage points higher than the previous year.</p>
<p><b>Identify any barriers to implementing initiatives:</b></p> <ul style="list-style-type: none"> <li>• High unable to contact member rates</li> <li>• Providers report high workload demands, time constraints, and reduced staff</li> </ul>
<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b></p> <ul style="list-style-type: none"> <li>• Reaching members where they are via community events, social media, text campaigns, and mailers.</li> <li>• Provide clear and concise provider education methods on cervical cancer screening guidelines via disseminating Cervical Cancer Screening Pocket Guides and provider alerts.</li> </ul>
<p><b>HSAG Assessment</b></p> 


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

Recommendation
A CR was not conducted last year; therefore, HSAG did not have prior year recommendations.

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

Recommendation
HSAG recommended that LDH provide ACLA with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which ACLA will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance).
Response
<p><b>Describe initiatives implemented based on recommendations:</b></p> <ul style="list-style-type: none"> <li>• Internal Secret Shopper that is completed monthly.             <ul style="list-style-type: none"> <li>Accepting new members</li> <li>Validating demographics</li> <li>Validate phone number and fax</li> <li>Validate Provider Type/Specialty Type</li> </ul> </li> <li>• Onsite demographic/provider validation (provider type, spec type, directory).</li> <li>• Updates validated in the system for accuracy.</li> <li>• Utilize Press Ganey to conduct the annual Access and Availability Survey. This survey assesses membership’s access to appointments for primary, specialty and behavioral healthcare services. Standards mandated by the Louisiana Department Health (LDH) and the National Committee for Quality Assurance (NCQA) are monitored. When gaps are identified, ACLA conducts a comprehensive analysis, identifying barriers, opportunities, and appropriate intervention as applicable.</li> </ul>

<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b>          ACLA has seen higher compliance rates received on the LDH Secret Shopper survey and received one of the highest scores on the LDH Q1 Secret Shopper Survey, which showed a compliance score of 76.25%.</p>
<p><b>Identify any barriers to implementing initiatives:</b></p> <ul style="list-style-type: none"> <li>Providers fail to timely notify ACLA of demographic updates as well as addition and terminations of practitioners.</li> </ul>
<p><b>Identify strategy for continued improvement or overcoming identified barriers</b></p> <ul style="list-style-type: none"> <li>ACLA will continue to complete monthly internal Secret Shopper surveys that have proven instrumental in improving compliance scores.</li> <li>Account Executives will educate providers at all site visits on network participation, the importance of timely notifications to ACLA on office locations and changes to accepting new patients.</li> <li>Ongoing education to providers on the use of our Provider Data Information Form (PDIF).</li> </ul>
<p><b>HSAG Assessment</b></p>

<p><b>Recommendation</b></p>
<p>HSAG recommended that ACLA conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent</p>
<p><b>Response</b></p>
<p><b>Describe initiatives implemented based on recommendations:</b>          On a monthly basis ACLA reviews practitioner and facility records validating Demographics, Type/Specialty, License, Levels of Care, Bed numbers and Ages. Analysis identified:</p> <ul style="list-style-type: none"> <li>Provider information sent over to the plan incorrectly</li> <li>Data input error</li> <li>Providers fail to timely notify ACLA of demographic updates as well as addition and terminations of practitioners.</li> </ul> <p>ACLA implemented a new application and database, LIFT, used to process and store credentialing data.</p>
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b>          ACLA has seen improved efficiency with the implementation of LIFT with streamlined processes reducing errors and improved data quality.</p>
<p><b>Identify any barriers to implementing initiatives:</b></p> <ul style="list-style-type: none"> <li>Lack of notification from the provider/provider group.</li> </ul>
<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b></p> <ul style="list-style-type: none"> <li>Account Executives continue to focus on educating providers during all site visits on network participation, the importance of timely notifications to ACLA on office locations, and reporting updates related to whether they are accepting new patients.</li> </ul>
<p><b>HSAG Assessment</b></p>



Recommendation
HSAG recommended that ACLA consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care.
Response
<p><b>Describe initiatives implemented based on recommendations:</b></p> <ul style="list-style-type: none"> <li>Account Executives validate that providers have access to tools or systems for verifying member eligibility prior to rendering services.</li> <li>Education on our NaviNet portal to use PDIF</li> <li>Conducted Appointment Availability Standards calls</li> </ul>
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b> N/A</p>
<p><b>Identify any barriers to implementing initiatives:</b></p> <ul style="list-style-type: none"> <li>Limited system access, lack of staff training and inconsistent processes for verifying member eligibility.</li> </ul>
<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b></p> <ul style="list-style-type: none"> <li>Continued improvement of education efforts will ensure providers remain informed about eligibility processes and promote consistency.</li> </ul>
HSAG Assessment


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

Recommendation
Encounter data validation was a new activity; therefore, HSAG did not have prior year recommendations.

**Table 12-6—Follow-Up on Prior Year's Recommendations for CAHPS**

Recommendation
HSAG recommended that ACLA conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for Rating of All Health Care compared to the national average and implement appropriate interventions to improve the performance related to the care members need.
Response
<p><b>Describe initiatives implemented based on recommendations:</b></p> <ul style="list-style-type: none"> <li>Conducted cross-functional analysis of Member Grievances, Quality of Care issues, and PCP Change data to detect common providers or facilities. None were identified.</li> <li>Analyzed Network Adequacy/Accessibility.</li> <li>Member satisfaction pulse survey implementation on ACLA's member website to assess member satisfaction year-round with health plan and providers.</li> </ul>

Recommendation
<ul style="list-style-type: none"> <li>Administration and analysis of the Post-Appointment Member Satisfaction Survey, utilizing provider scorecards to identify low-performing providers for targeted educational outreach.</li> <li>Updated value-added benefits to include adult dental coverage.</li> <li>Launched "Ask me about CAHPS" initiative and participation in the Member Advisory Council to actively solicit and integrate member feedback.</li> </ul>
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b></p> <ul style="list-style-type: none"> <li>Adult-Rating of Healthcare demonstrated a 6.5% increase when compared to the previous year's rate.</li> <li>Child-Rating of Healthcare demonstrated 1.7% increase when compared to the previous year's rate.</li> </ul>
<p><b>Identify any barriers to implementing initiatives:</b></p> <p>None; improved performance was seen in the Rating of Healthcare measure for both adult and child for the recent measurement period.</p>
<p><b>Identify strategy for continued improvement or overcoming identified barriers:</b></p> <ul style="list-style-type: none"> <li>Continue interventions listed</li> <li>Analyze website survey results to assess member satisfaction with the health plan.</li> </ul>
HSAG Assessment


**Table 12-7—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey**

Recommendation
None identified.

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

Recommendation
None identified.

**Table 12-9—Follow-Up on Prior Year's Recommendations for QRS**

Recommendation
The MCEs were directed to reference the recommendations made for PMV and CAHPS as the Health Plan Report Card reflects HEDIS and CAHPS results. HSAG did not make additional recommendations specific to the QRS activity.



## Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from ACLA’s HEP submission from July 2025.

### Health Equity Plan

HSAG reviewed ACLA’s HEP<sup>18</sup> submitted July 2025. 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.

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<sup>18</sup> Please note that the narrative within the “MCE Response” section was provided by the MCE and has not been altered by HSAG except for formatting.

## Development and Implementation of Focus Areas

### 1. Health Equity Action Plan by Focus Area

#### A. Focus Area: Monitoring and Improving Internal Processes

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

- **Participant Changes** (if applicable): N/A
- **Activities accomplished between January and June 2025:**

##### **Enrollee Advisory Committee**

- The Enrollee Advisory Council (EAC) has been leveraged successfully to support the development of standardized questions that improve equity within ACLA's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) communications for Black and Hispanic Enrollees; inform best practices for the EDPST focus group (LET'S CHAT); and provide feedback on the development of the Community Based Organization (CBO) Equity network. To better capture Enrollee needs, the EAC was embedded during all community events. This structure provides a streamlined approach to Enrollee support, an increase in the capturing of Social Determinants of Health (SDOH) needs and addresses a diverse set of barriers during events. Examples of these activities include EACs during Community Baby Showers and *Caritas on the Move*, a series of events that focus on exercise education. To date, the EAC has held one (1) adult Enrollee meeting in-person and virtually across our two Community Wellness Center locations, highlighting the Member and Family Engagement and Member Orientation Night. Thirty-eight (38) attendees (35 in person and 3 virtual AmeriHealth Caritas Louisiana Enrollees) participated across both locations. During this meeting, the EAC discussed topics including, but not limited to, communication preferences, member portal, and ACLA benefits.

##### **Wider Circle:**

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

Since January 2025, their continued efforts have identified the top three SDOH needs reported by Enrollee participants: food insecurity, educational services, and dental. Wider Circle has also made the following SDOH referrals to date within these top areas of identified need:

- Food Insecurity: 999
- Educational Services: 910
- Dental: 256

Recurring calls between AmeriHealth Caritas Louisiana and Wider Circle continue to be held to address project needs, barriers to member engagement and outreach, and required reporting deliverables focused on opportunities for member engagement related to market-specific performance. Additionally, there have been increased onsite and virtual trainings with ACLA staff to coordinate activities.

Between January and June 2025, the number of enrolled participants is 4,038, which exceeds the goal of 2,667. The top 10 parishes of the enrolled membership are represented below. The following image provides a visual of the top ten Parishes with Enrollee participation.

# Enrolled Membership by Parish

- **Top 10 Parishes:**

County or Parish	Louisiana Enrolled Member	%GT Louisiana Enrolled Member
Lafayette Parish	740	18.33%
East Baton Rouge Parish	511	12.65%
Orleans Parish	419	10.38%
Jefferson Parish	319	7.90%
Calcasieu Parish	245	6.07%
Rapides Parish	218	5.40%
St. Landry Parish	172	4.26%
St. Martin Parish	155	3.84%
Caddo Parish	142	3.52%
Iberia Parish	130	3.22%

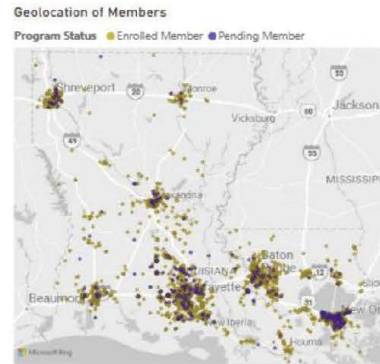


Figure 1 Enrollment by Parish in Wider Circle

Metric	Pacing	Results
Enrolled Participants	● <b>At Goal</b>	<b>4,038</b> (Goal of 2,667) ○ In-person Event: 21% ○ Virtual Event: 3%
Participant Connections	● <b>At Goal</b>	<b>47,238</b> (Goal of 9,990) ● Telephonic: 76% ● In-person event: 21% ● Virtual event: 3%
95% Contact rate	● <b>At Goal</b>	<b>99%</b>
70% Positive Health Actions	● <b>At Goal</b>	<b>81%</b>
95% SDOH Referral Rate	● <b>On Track</b>	<b>98%</b>
Net Promoter Score (NPS) > 50	● <b>On Track</b>	<b>78</b>
Complaint Rate < 3/1000	● <b>On Track</b>	<b>0</b>

Figure 2 Total Outcomes of Participant Engagement

- **Activities expected to be accomplished by December 2025:**

**Enrollee Advisory Committee**

- The Plan will continue to support our Equity strategy by including Care Managers from the Population Health team to discuss our Bright Start, Mom’s Meals, and Care Management programs, with the intent to educate Enrollees on these offerings and collect data on barriers to engagement. The conversations are designed to educate Enrollees on Plan offerings that support SDOH, maternal care and diabetes management. Ongoing equity enhancement and integration into this activity will be addressed and strategized in recurring Enrollee Engagement equity workgroup discussions, including mechanisms to address language needs. There are two additional EAC and one YAC meetings scheduled through December 2025.

- The Marketing and Communications team, in conjunction with Member and Community Engagement team, partners with the Health Equity Director, Health Equity and Quality Analyst, Community Health Education, Population Health, and Quality to conduct regular assessments of literature and identify gaps in written materials for ACLA Enrollees. When editing existing or developing new content, consideration for special populations will include:
  - People with health conditions or impairments
  - People with Limited English Proficiency (LEP)
  - People with low health literacy
  - Racial and ethnic minorities
  - Sexual and gender minorities
- Stakeholders will develop a set of standardized questions that address the SDOH and cultural needs of Black and Hispanic Enrollees to be used when collecting information on barriers to Prenatal and Postpartum care, and diabetic care from Enrollees when reviewing communications projects and materials.

Monthly recurring events by Wider Circle through December of 2025:

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

New member engagement events incorporated by Wider Circle in 2025:

- Wider Circle Walks- In-person and virtual events to build community and foster awareness by supporting emotional well-being through peer-supported activity.
- Lunch and Learns- During this event, Enrollees will meet to learn about access to local resources and discuss health-related topics.

**Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025:**  
No challenges or delays projected.

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

- **Participant Changes (if applicable):** N/A
- **Activities accomplished between January and June 2025:** The Plan's EPSDT team facilitates quarterly group discussions designed to educate and gain insight from Enrollees and caregivers on personal and social challenges faced when accessing health care. The group has been renamed to Let's CHAT (Child Health Activity Talks). One event has been held thus far in 2025, Ticket to Health Event, cohosted by ACLA and the New Orleans Pelicans. Let's CHAT discussed the importance of health screenings and preventive services for children and adolescents. Children and adolescents (ages 8-16) attended the event to learn about the importance of staying active and eating healthy.
  - 1<sup>st</sup> Let's CHAT: March 29, 2025 (45 attendees consisting of children and adults)
- **Activities expected to be accomplished by December 2025:** Let's CHAT will continue meeting with three (3) additional events to be completed by December 2025.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025:** Initial challenges faced by Let's CHAT centered on parental engagement of ACLA enrollees. These challenges and barriers are being addressed to increase participation in forthcoming sessions.

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

- **Participant Changes (if applicable):** N/A
- **Activities accomplished between January and June 2025:** During the first half of the year, the Marketing and Communication department engaged Feigley Communications and Percy & Company to conduct a series of focus group discussions with Medicaid enrollees (of different health plans) on behalf of ACLA. Two groups were held in each of three cities: Lake Charles, Shreveport, and Baton Rouge.

At each event, Enrollees discussed: plans chosen and reasons for choice; healthcare needs and plan support; plan benefits (awareness, understanding & importance); and communications.

A total of 64 participants, with approximately 10 to 12 individuals in attendance each session, participated across the set of six focus groups which included:

- Lake Charles: Residence Inn, April 23, 2025 (24 attendees)
- Shreveport: Holiday Inn Downton, April 24, 2025 (20 attendees)
- Baton Rouge: Crowne Plaza Hotel, April 30, 2025 (20 attendees)

#### Summary of the feedback we received:

- Parents of eligible children were more likely to have them on a different plan that best suited their child's needs.
- Those with chronic conditions (cancer, heart disease, bariatric, respiratory, and gender transitioning) stated that their physician relationships were very important and chose their plan based on their specialist being in the plan network.
- Recommendations from the group for future communications:
  - Keep it simple.
  - Cut out legalese and write it in a way we can understand it.
  - Tell us when things change.
  - Bullet points are much better than long, legal document.
- Persons with chronic condition and parents were the most informed and the most proactive in seeking information.
- **Activities expected to be accomplished by December 2025:** In the second half of the year through December 2025, we plan to continue engaging Enrollees for feedback on their healthcare needs, plan support and benefits, and communication preferences to ensure the relay of messaging and materials are comprehensive and culturally relevant at community events partnering with the MACE team.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025:** No challenges, and/or delays anticipated.

### B. Focus Area: HEDIS Initiatives

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

- **Participant Changes:** N/A
- **Activities and achievements accomplished between January and June 2025:**

Health Equity Tracking Report: The Plan has adopted a Health Equity tracking report that is inclusive of an accompanying toolkit designed by the Health Equity team as a tool to design interventions aimed at populations with disparate outcomes. Ongoing reviews of the memo with the Health Equity team aim to

support intervention development through in-depth discussions and planning that address the following memo components for Black, Hispanic and Rural Enrollees:

- Targeted groups and supporting data.
- Intervention Timeline.
- Geographic area targeted for Intervention (where applicable).
- Providers with care gaps associated with HEDIS measures targeted for improvement.
- Baseline data and improvement goal.
- Barriers to care experienced by targeted group.
- Description of planned actions that support improvement.
- Effectiveness planned actions.
- Decision to continue activity or change approach based on outcomes.
- Engagement with providers on best practices to support closing identify barriers of care.
- Connection with Enrollees upon discharge of care to ensure needs are met.
- Track and measure health disparities stratified by demographic, geography and provider level data and outcomes.
- Increased educational touchpoints with internal staff to support integration of best practices into current processes to reduce disparities.
- Utilize CBO network to prioritize and enhance access to care.
- Connect culturally responsive SDOH resources with CBOs and Enrollees.
- Prioritize communication through omni-channel processes to ensure timely member information on quality and access to care.

Language access: The Health Equity team has an Enterprise-wide goal to increase data collection of race, ethnicity, and language (REL) make-up for providers and their practice. This information is helpful in directing the unique needs of diverse populations to more effective and equitable care. The tools developed to increase Provider REL data collection include the following:

- Provider REL Data Collection Training for Account Executives and Credentialing Associates
  - Provider Sentiment Survey for Account Executives
  - Equity Provider Definition Sheet
  - REL Data Collection One-Pager for Account Executives and Credentialing Associates
  - Provider REL Data Collection Article for Providers
- **Diabetes (CDC)**
- For 2025, the Plan has an enhanced focus on enhancing the importance of controlling diabetes for Black, Hispanic, and Rural Enrollees. The goals for Diabetes (CDC) include the following:
    - Diabetes CDC: Increase % of members with diabetes (types 1 and 2) who had each of the following during the measurement year:
      - HbA1c test showing blood sugar control (result <9.0%) for Enrollees aged 18-75, retinal eye exam, controlled BP (<140/90 mm Hg), and blood and urine kidney health screening for Enrollees aged 18-85.
  - The activities since January 2025 include:

- Member reminder letters and outreach calls to promote completion of Diabetic screenings (Hemoglobin A1C, Kidney Screening, Retinal Eye Exam) and help with appointment scheduling and transportation needs.
- Mailers to members with most recent Hemoglobin A1C value >9% to educate on importance of retest and diabetic self-management.
- Provider alert and education to improve diabetic care gap closures.
- Promotion of weight management program that includes registered dietician visits and gym membership or at-home fitness kits for members with a primary diagnosis of hypertension or diabetes.
- Regions 5 & 8 Initiatives (Disparate Regions)
  - Targeted outreach to unable to contact Black/ African American and White members to assist with education on the importance of routine screening, promote in-home diabetic screening kits, if appropriate, and transportation as needed.
- **Maternity (PPC)**
  - For 2025, the Plan has an enhanced focus on reinforcing the importance of timely prenatal care and postpartum care for Black, Hispanic, and Rural Enrollees. The goals for Maternity (PPC) include the following:
    - Timeliness of Prenatal Care: Increase the number of members receiving prenatal visit in the first trimester or within 42 days of enrollment in the plan.
    - Postpartum: Increase the number of members receiving a postpartum visit within 7-84 days of delivery.
  - The activities and accomplishments since January 2025 include:
    - Community Health Navigator referrals to initiate face to face outreach visits to members unable to contact via phone with outstanding or unscheduled postpartum appointments.
    - Promotion of information on pregnancy, postpartum, and transportation services at community events.
    - Doula referrals to promote postpartum care with members.
    - Telephonic outreach to members during inpatient and post discharge to assist with scheduling postpartum visit.
    - Member mailers promoting postpartum appointment reminder letters and educational postpartum brochures.
    - Regions 7 & 8 Initiatives (Disparate Regions)
      - Face to Face outreach visits with all members in the postpartum period who have not scheduled or attended a postpartum appointment by day 56.
      - Additional outreach to unable to contact Black/ African American members to assist with education on telehealth, if appropriate, and transportation as needed.

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

- **Activities expected to be accomplished by December 2025**: The plan will continue to use the tracking report and toolkit to measure, report and improve interventions.

- **Diabetes (CDC)**
  - Targeted provider outreach on billing CPT CAT II codes for Hemoglobin A1C value >9% for attributed members, no A1C result billed in measurement year, and/or high noncompliance rates who are not using CPT CAT II codes.
  - Leverage the mobile wellness bus, FQHCs, and faith based organizations to deliver on-site, at home diabetic screenings and education to increase access and member compliance with diabetic care measures in rural areas.
  - Regions 5 & 8 Initiatives (Disparate Regions)
    - Additional targeted outreach to unable to contact Black/ African American and White members to assist with education on the importance of routine screening, promote in-home diabetic screening kits, if appropriate, and transportation as needed.
- **Maternity (PPC)**
  - Implement telehealth services in all regions after successful Community Health Navigator contact with member during postpartum period.
  - Provider alert and education to improve maternity health care services.
  - Regions 7 & 8 Initiatives (Disparate Regions)
    - Face to Face outreach visits with all members in the postpartum period who have not scheduled or attended a postpartum appointment by day 56.
    - Additional outreach to unable to contact Black/ African American members to assist with education on telehealth, if appropriate, and transportation as needed.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025:** No challenges or delays projected.

## Focus Area: Community Partnerships and SDOH

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

- **Participant Changes:** N/A
- **Activities and achievements accomplished between January and June 2025:** The Plan is continuing to engage the CBO Equity network in 2025 with the overall objective of increasing engagement of African American and Hispanic Enrollees in Plan programs and services that address SDOH. Participants in the network continue to be engaged monthly to share information on best practices for referrals, discuss patient barriers and explore ways to further leverage existing relationships between Managed Care and Community Based Organizations. The activities since January of 2025 include:
  - The creation of a workgroup focused on statewide recruitment of additional CBOs serving rural services areas, and communities consisting of Black and Hispanic populations.
  - Areas of collaborative focus in 2025, include but are not limited to: pregnancy, adult, child, behavioral health services for Black, Hispanic, and rural Enrollees.
  - The Plan has engaged with 4 CBOs since January 2025.

Sickle Cell Workgroup: The Plan has an enhanced focus on promoting early identification and intervention to enrollees living with Sickle Cell Disease (SCD). There are specific challenges associated with SCD in infants, children, adolescents, and during transition to adulthood that are drivers of health disparities. The Sickle Cell Workgroup was established to explore opportunities to improve care, support, and health outcomes important for long-term health and well-being for enrollees with SCD. Participants in the workgroup represent Case Management, Utilization Management, Quality, Communications, Provider

Network Management, Community Engagement, Finance, and Health Equity. The activities since January 2025 include:

- The creation of the Sickle Cell workgroup focused on statewide improvement of the health outcomes and curbing the trend in cost of care for enrollees with SCD.
- The workgroup dissected actuarial data revealing an increasing trend of Emergency Department and inpatient utilization that have increased costs for enrollees diagnosed with SCD.
- Areas of collaborative focus in 2025, include but are not limited to: identifying member specific care gaps to be closed, raising awareness of community-based SCD resources, and partnering with the statewide Sickle Cell community based organizations to alleviate health disparities.
- The Plan has engaged with one (1) Sickle Cell CBO since January 2025 with efforts underway of engaging four (4) additional Sickle Cell CBOs.

**Rural Health:** The Plan has continued to work towards removing barriers to care and overcoming health disparities for enrollees within the most remote areas of the state due to geographic isolation, socioeconomic factors, and shortages of healthcare professionals. In efforts to combat these health disparities, the Plan has engaged with the Louisiana Rural Health Association and the Foundation for Wellness to address these challenges faced in rural areas. The activities since January 2025 include:

- Engagement with the Louisiana Rural Health Association and the Foundation for Wellness regarding conferences and projects aimed at reducing health disparities in rural communities of the state.
- Areas of collaborative focus in 2025, include but are not limited to, rural care coordination, health-related social needs, childhood obesity, and maternal health.

- **Activities expected to be accomplished by December 2025:** The Plan will recruit CBOs in efforts to establish partnership agreements to create a pathway for health-related services and support for members and communities. The partnership agreements will address some of the following topics:
  - Birth outcomes
  - Mental health
  - Health-related social needs
  - Chronic diseases
  - Maternal health
  - Sickle Cell Disease
  - Rural Health
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025:** No challenges, and/or delays anticipated.

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

- **Participant Changes:** N/A
- **Activities and achievements accomplished between January and June 2025:** The Plan continues to emphasize the importance of member referrals to address SDOH needs. However, the decrease in plan membership has driven down the number of referrals, affecting the current overall improvement goal of a 2% increase in referrals year-over-year. Current referrals to date are below:

2023 Total	2024 Total	2025 January- June
382	647	288

- **Activities expected to be accomplished by December 2025:** Continued development and expansion of activities to drive improvements in SDOH capture.
- **Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025:** No challenges, and/or delays anticipated.

## ***Cultural Responsiveness and Implicit Bias Training***

### **2. Cultural Responsiveness and Implicit Bias Training**

- A.** Staff and provider trainings conducted (e.g., training components, number and type of attendees, length of training and format) between January and June 2025
- Staff
    - Annual Health Equity and Cultural Responsiveness Training 2025-2026 (May 2025): These trainings are required for all new hires and refresher training is required for all current associates. This training is updated annually by the Director of Quality Health Equity and administered and tracked by the Corporate Learning and Development team which provides quarterly reporting for new trainings, which is required upon onboarding.
      - 8 associates have completed this training to date in 2025.
  - Provider Trainings
    - Quarter 1 – March 19, 2025 (8 Registered and 3 Attendees)
  - Training Components
    - Health Equity and Health Inequity
    - Concepts of Equality vs Equity vs Justice
    - Health Disparities
    - Cultural Competency
    - Bias
    - ACLA's Race, Ethnic, and Linguistic membership make-up
    - Importance of building patient trust
    - Social Determinants of Health and their impact on healthcare
    - Concepts of Culturally and Linguistically Appropriate Services
  - LGBTQIA+: Sexual Orientation and Gender Identity Data Collection Training: AmeriHealth Caritas Louisiana continues to promote trainings on sexual orientation and gender identity (SOGI) data collection from Enrollees. This training is required of all Associates who will complete this process during member encounters in efforts to understand the specific health needs of the LGBTQIA+ community and be able to service these Enrollees respectfully. The SOGI data collection supports the contractual requirement for assessing the quality of care for Enrollees based on sexual orientation (2.16.2.3.9), and Health Equity Accreditation requirements from the National Committee for Quality Assurance. The collection of this SOGI data provides ACLA with the opportunity to learn more about the many health disparities faced by the LGBTQIA+ people and measure the quality of care provided. Training objectives included the following:
    - Completing the SOGI assessment in the Plan's health management system.
    - Identifying LGBTQIA+ terminology and basic concepts.
    - Identifying member privacy and confidentiality policies.
    - Recognizing the health disparities that affect LGBTQIA+ people.
    - Understanding why AmeriHealth Caritas is collecting sexual orientation and gender identity data from Enrollees.
    - Using inclusive language and gender pronouns to effectively communicate health concerns for LGBTQIA+ people
    - Using member resources developed to address specific LGBTQIA+ population needs.

- Successful utilization of application to collect SOGI data.
  - This is a required training for all new hires that are in Care Management.
- Health Equity Learning Collaborative: Listen Learn Lead Training: AmeriHealth Caritas continues to promote achieving consistency in health equity and improving quality of care within intentional application of best practices for providers within the network. This collaborative provides ACLA with the opportunity to identify providers demonstrating best practices with effective health outcomes to lead discussions of models of improvement with the provider network related to pediatrics and behavioral health. The primary goals for the training collaborative included the following:
  - Identify and reward health equity leaders in health.
  - Close the gap between science and practice.
  - Advance knowledge of innovative policies programs, strategies, and practices that promote health equity.
  - Showcase best performance that has been accomplished in other settings.
  - Develop and support leaders to carry out reform work at the policy and practice levels.
  - Lead scalable change by positioning ACLA to be the leader in health innovation.

The activities since January 2025 include:

- Identified key providers and metrics for the pediatric and behavioral health learning sessions.

**B. Additional trainings expected to be conducted by December 2025**

- a. Provider Trainings
  - i. Quarter 2 – June 18, 2025
  - ii. Quarter 3 – September 17, 2025
  - iii. Quarter 4 – December 17, 2025
- b. Upcoming Training for Associates
  - i. Member Facing Associate Cultural Competency Training (October 22, 2025)
- c. Health Equity Learning Collaborative: Listen Learn Lead Training
  - i. Pediatric and behavioral health focused learning sessions are scheduled to be completed in Quarters 3 and 4 of 2025.

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

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

## ***Stratify MCO Results on Attachment H Measures***

### **3. Stratified Results on Select Attachment H Measures (Measure #57)**

Summarize baseline information for Attachment H measures, including any stratifications of data from CY2024 where available.

**i. Pregnancy:** Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44, Prenatal and Postpartum Care (PPC), Low-Risk Cesarean Delivery (LRCD) (CY 2024)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Percentage of Low Birthweight Births	Total	3,062	3,062	0	416	13.59%
	<b>Race</b>					
	White	1,077	1,077	0	111	10.31%
	Black or African American	1,513	1,513	0	271	17.91%
	American Indian and Alaska Native	34	34	0	4	11.76%
	Asian	20	20	0	0	0.00%
	Native Hawaiian or Other Pacific Islander	1	1	0	0	0.00%
	Some Other Race	0	0	0	0	N/A
	Two or More Races	163	163	0	8	4.91%
	Asked but No Answer	0	0	0	0	N/A
	Unknown	254	254	0	22	8.66%
	<b>Ethnicity</b>					
	Hispanic or Latino	658	658	0	57	8.66%
	Not Hispanic or Latino	1,786	1,786	0	272	15.23%
	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	618	618	0	87	14.08%
	<b>Sex</b>					
	Male	1,565	1,565	0	200	12.78%
	Female	1,497	1,497	0	216	14.43%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	650	650	0	85	13.08%
	Urban	2,412	2,412	0	331	13.72%
Unknown	0	0	0	0	N/A	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
	Total	1,745	1,745	198	0	11.35%
	<b>Race</b>					
	White	672	672	72	0	10.71%
	Black or African American	937	937	106	0	11.31%
	American Indian and Alaska Native	20	20	3	0	15.00%

<b>Contraceptive Care- Postpartum Women (ages 21-44), most or moderately effective, 3 day rate</b>	Asian	14	14	0	0	0.00%	
	Native Hawaiian or Other Pacific Islander	1	1	0	0	0.00%	
	Some Other Race	0	0	0	0	N/A	
	Two or More Races	24	24	4	0	16.67%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	77	77	13	0	16.88%	
	<b>Ethnicity</b>						
	Hispanic or Latino	222	222	30	0	13.51%	
	Not Hispanic or Latino	1,169	1,169	129	0	11.04%	
	Declined Ethnicity	0	0	0	0	N/A	
	Unknown Ethnicity	354	354	39	0	11.02%	
	<b>Geography</b>						
	Rural	411	411	38	0	9.25%	
	Urban	1,334	1,334	160	0	11.99%	
	Unknown	0	0	0	0	N/A	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate	
<b>Contraceptive Care- Postpartum Women (ages 21-44), most or moderately effective, 90 day rate</b>	Total	1,745	1,745	867	3	49.86%	
	<b>Race</b>						
	White	672	672	342	1	51.04%	
	Black or African American	937	937	458	2	49.09%	
	American Indian and Alaska Native	20	20	10	0	50.00%	
	Asian	14	14	3	0	21.43%	
	Native Hawaiian or Other Pacific Islander	1	1	0	0	0.00%	
	Some Other Race	0	0	0	0	N/A	
	Two or More Races	24	24	9	0	37.50%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	77	77	45	0	58.44%	
	<b>Ethnicity</b>						
	Hispanic or Latino	222	222	99	0	44.59%	
	Not Hispanic or Latino	1,169	1,169	607	3	52.18%	
	Declined Ethnicity	0	0	0	0	N/A	
	Unknown Ethnicity	354	354	161	0	45.48%	
	<b>Geography</b>						
	Rural	411	411	220	2	54.01%	

	Urban	1,334	1,334	647	1	48.58%
	Unknown	0	0	0	0	N/A

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
<b>Contraceptive Care- Postpartum Women (ages 21-44), LARC 3 day rate</b>	Total	1,745	1,745	29	0	1.66%
	<b>Race</b>					
	White	672	672	7	0	1.04%
	Black or African American	937	937	20	0	2.13%
	American Indian and Alaska Native	20	20	0	0	0.00%
	Asian	14	14	0	0	0.00%
	Native Hawaiian or Other Pacific Islander	1	1	0	0	0.00%
	Some Other Race	0	0	0	0	N/A
	Two or More Races	24	24	0	0	0.00%
	Asked but No Answer	0	0	0	0	N/A
	Unknown	77	77	2	0	2.60%
	<b>Ethnicity</b>					
	Hispanic or Latino	222	222	7	0	3.15%
	Not Hispanic or Latino	1,169	1,169	16	0	1.37%
	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	354	354	6	0	1.69%
	<b>Geography</b>					
	Rural	411	411	2	0	0.49%
	Urban	1,334	1,334	27	0	2.02%
	Unknown	0	0	0	0	N/A

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
<b>Contraceptive Care- Postpartum Women (ages 21-44), LARC 90 day rate</b>	Total	1,745	1,745	220	2	12.72%
	<b>Race</b>					
	White	672	672	90	0	13.39%
	Black or African American	937	937	104	2	11.31%
	American Indian and Alaska Native	20	20	5	0	25.00%
	Asian	14	14	1	0	7.14%
	Native Hawaiian or Other Pacific Islander	1	1	0	0	0.00%
	Some Other Race	0	0	0	0	N/A

	Two or More Races	24	24	3	0	12.50%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	77	77	17	0	22.08%	
	<b>Ethnicity</b>						
	Hispanic or Latino	222	222	31	0	13.96%	
	Not Hispanic or Latino	1,169	1,169	153	2	13.26%	
	Declined Ethnicity	0	0	0	0	N/A	
	Unknown Ethnicity	354	354	36	0	10.17%	
	<b>Geography</b>						
	Rural	411	411	46	1	11.44%	
	Urban	1,334	1,334	174	1	13.12%	
	Unknown	0	0	0	0	N/A	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Medical Records	Numerator By Supplemental	Rate
<b>Prenatal and Postpartum Care: Timeliness of Prenatal Care</b>	Total	2,700	2,700	2,047	0	10	76.19%
	<b>Race</b>						
	White	978	978	789	0	2	80.88%
	Black or African American	1,499	1,499	1,090	0	6	73.12%
	American Indian and Alaska Native	32	32	23	0	0	71.88%
	Asian	18	18	16	0	0	88.89%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	0	N/A
	Some Other Race	0	0	0	0	0	N/A
	Two or More Races	48	48	34	0	0	70.83%
	Asked but No Answer	0	0	0	0	0	N/A
	Unknown	125	125	95	0	2	77.60%
	<b>Ethnicity</b>						
	Hispanic or Latino	382	382	282	0	1	74.08%
	Not Hispanic or Latino	1,769	1,769	1,364	0	6	77.44%
	Declined Ethnicity	0	0	0	0	0	N/A
	Unknown Ethnicity	549	549	401	0	3	73.59%
	<b>Sex</b>						
	Male	1	1	0	0	0	0.00%
	Female	2,699	2,699	2,047	0	10	76.21%
	Unknown	0	0	0	0	0	N/A
	<b>Geography</b>						

Rural	741	741	583	0	0	78.68%
Urban	1,939	1,939	1,451	0	10	75.35%
Unknown	20	20	13	0	0	65.00%

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Medical Records	Numerator By Supplemental	Rate
<b>Prenatal and Postpartum Care: Postpartum Care</b>	Total	2,697	411	296	36	2	81.27%
	<b>Race</b>						
	White	976	164	126	17	2	88.41%
	Black or African American	1,498	219	149	18	0	76.26%
	American Indian and Alaska Native	32	5	4	0	0	80.00%
	Asian	18	1	1	0	0	100.00%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	0	N/A
	Some Other Race	0	0	0	0	0	N/A
	Two or More Races	48	6	3	1	0	66.67%
	Asked but No Answer	0	0	0	0	0	N/A
	Unknown	125	16	13	0	0	81.25%
	<b>Ethnicity</b>						
	Hispanic or Latino	381	59	43	4	0	79.66%
	Not Hispanic or Latino	1,767	283	209	25	2	83.39%
	Declined Ethnicity	0	0	0	0	0	N/A
	Unknown Ethnicity	549	69	44	7	0	73.91%
	<b>Sex</b>						
	Male	1	0	0	0	0	N/A
	Female	2,696	411	296	36	2	81.27%
	Unknown	0	0	0	0	0	N/A
	<b>Geography</b>						
	Rural	739	117	78	16	1	81.20%
	Urban	1,938	291	216	20	1	81.44%
	Unknown	20	3	2	0	0	66.67%

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
<b>Low-Risk Cesarean Delivery</b>	Total	691	691	0	187	27.06%
	<b>Race</b>					
	White	233	233	0	60	25.75%
	Black or African American	355	355	0	99	27.89%

	American Indian and Alaska Native	6	6	0	2	33.33%	
	Asian	5	5	0	1	20.00%	
	Native Hawaiian or Other Pacific Islander	0	0	0	0	N/A	
	Some Other Race	0	0	0	0	N/A	
	Two or More Races	37	37	0	9	24.32%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	55	55	0	16	29.09%	
	<b>Ethnicity</b>						
	Hispanic or Latino	150	150	0	38	25.33%	
	Not Hispanic or Latino	393	393	0	111	28.24%	
	Declined Ethnicity	0	0	0	0	N/A	
	Unknown Ethnicity	148	148	0	38	25.68%	
	<b>Geography</b>						
	Rural	155	155	0	45	29.03%	
	Urban	536	536	0	142	26.49%	
Unknown	0	0	0	0	N/A		

**ii. Child:** Well Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits (WCV) (CY 2024)

	Category	Eligible Population	Denominator	NumeratorBy Admin	NumeratorByS upplemental	Rate	
<b>Well-Child Visits in the First 30 Months of Life: First 15 Months</b>	Total	3,384	3,384	2,133	16	63.50%	
	<b>Race</b>						
	White	745	745	502	4	67.92%	
	Black or African American	1,360	1,360	794	6	58.82%	
	American Indian and Alaska Native	17	17	10	0	58.82%	
	Asian	22	22	13	0	59.09%	
	Native Hawaiian or Other Pacific Islander	6	6	5	0	83.33%	
	Some Other Race	0	0	0	0	N/A	
	Two or More Races	363	363	250	1	69.15%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	871	871	559	5	64.75%	
	<b>Ethnicity</b>						
	Hispanic or Latino	546	546	328	3	60.62%	
	Not Hispanic or Latino	1,007	1,007	674	3	67.23%	

	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	1,831	1,831	1,131	10	62.32%
	<b>Sex</b>					
	Male	1,733	1,733	1,088	10	63.36%
	Female	1,651	1,651	1,045	6	63.66%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	782	782	440	3	56.65%
	Urban	2,578	2,578	1,680	12	65.63%
	Unknown	24	24	13	1	58.33%

	Category	Eligible Population	Denominator	NumeratorBy Admin	NumeratorByS supplemental	Rate
Well-Child Visits in the First 30 Months of Life: 15 Months - 30 Months	Total	3,485	3,485	2,485	26	72.05%
	<b>Race</b>					
	White	885	885	628	10	72.09%
	Black or African American	1,615	1,615	1,106	9	69.04%
	American Indian and Alaska Native	16	16	10	0	62.50
	Asian	27	27	25	0	92.59%
	Native Hawaiian or Other Pacific Islander	1	1	1	0	100.00%
	Some Other Race	0	0	0	0	N/A
	Two or More Races	286	286	241	1	84.62%
	Asked but No Answer	0	0	0	0	N/A
	Unknown	655	655	474	6	73.28%
	<b>Ethnicity</b>					
	Hispanic or Latino	555	555	383	2	69.37%
	Not Hispanic or Latino	1,089	1,089	824	9	76.49%
	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	1,841	1,841	1,278	15	70.23%
	<b>Sex</b>					
	Male	1,790	1,790	1,299	11	73.18%
	Female	1,695	1,695	1,186	15	70.86%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	906	906	588	2	65.12%
	Urban	2,550	2,550	1,886	24	74.90%
	Unknown	29	29	11	0	37.93%

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Child and Adolescent Well-Care Visits (WCV)	Total	67,183	67,183	36,106	44	53.81%
	<b>Race</b>					
	White	21,297	21,297	10,638	12	50.01%
	Black or African American	36,373	36,373	19,389	30	53.39%
	American Indian and Alaska Native	498	498	256	0	51.41%
	Asian	842	842	501	0	59.50%
	Native Hawaiian or Other Pacific Islander	102	102	69	0	67.65%
	Some Other Race	0	0	0	0	N/A
	Two or More Races	2,230	2,230	1,526	1	68.48%
	Asked but No Answer	0	0	0	0	N/A
	Unknown	5,841	5,841	3,727	1	63.82%
	<b>Ethnicity</b>					
	Hispanic or Latino	13,945	13,945	7,378	6	52.95%
	Not Hispanic or Latino	26,234	26,234	15,161	21	57.87%
	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	27,004	27,004	13,567	17	50.30%
	<b>Sex</b>					
	Male	33,637	33,637	17,747	26	52.84%
	Female	33,546	33,546	18,359	18	54.78%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	17,309	17,309	8,586	15	49.69%
	Urban	49,353	49,353	27,409	28	55.59%
	Unknown	5216	5216	111	1	21.50%

**iii. Adult:** Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening (CY 2024)

	Category	Initial Population	Denominator	Numerator By Admin	Numerator By EHR	Numerator By Case	Numerator By HIERegistry	Rate
Colorectal Cancer Screening	Total	16,309	15,949	7,151	530	0	0	48.16%
	<b>Race</b>							
	White	7,250	7,070	3,317	173	0	0	49.36%
	Black or African American	7,367	7,213	3,146	293	0	0	47.68%
	American Indian and Alaska Native	140	135	74	1	0	0	55.56%
	Asian	311	307	160	22	0	0	59.28%

	Native Hawaiian or Other Pacific Islander	6	6	3	0	0	0	50.00%	
	Some Other Race	0	0	0	0	0	0	N/A	
	Two or More Races	239	236	90	7	0	0	41.10%	
	Asked but No Answer	0	0	0	0	0	0	N/A	
	Unknown	996	982	361	34	0	0	40.22%	
	<b>Ethnicity</b>								
	Hispanic or Latino	1,660	1,628	609	58	0	0	40.97%	
	Not Hispanic or Latino	10,532	10,261	5,382	388	0	0	56.23%	
	Declined Ethnicity	0	0	0	0	0	0	N/A	
	Unknown Ethnicity	4,117	4,060	1,160	84	0	0	30.64%	
	<b>Sex</b>								
	Male	7,152	6,983	2,766	222	0	0	42.79%	
	Female	9,157	8,966	4,385	308	0	0	52.34%	
	Unknown	0	0	0	0	0	0	N/A	
	<b>Geography</b>								
	Rural	4,588	4,470	2,013	109	0	0	47.47%	
	Urban	11,605	11,366	5,109	419	0	0	48.64%	
	Unknown	116	113	29	2	0	0	27.43%	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate	
HIV Viral Load Suppression	Total	615	615	502	0	81.63%	
	<b>Race</b>						
	White	102	102	79	0	77.45%	
	Black or African American	485	485	403	0	83.09%	
	American Indian and Alaska Native	4	4	2	0	50.00%	
	Asian	0	0	0	0	N/A	
	Native Hawaiian or Other Pacific Islander	0	0	0	0	N/A	
	Some Other Race	0	0	0	0	N/A	
	Two or More Races	11	11	8	0	72.73%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	13	13	10	0	76.92%	
	<b>Ethnicity</b>						
	Hispanic or Latino	79	79	63	0	79.75%	
	Not Hispanic or Latino	411	411	341	0	82.97%	
	Declined Ethnicity	0	0	0	0	N/A	

	Unknown Ethnicity	125	125	98	0	78.40%
	<b>Sex</b>					
	Male	349	349	287	0	82.23%
	Female	266	266	215	0	80.83%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	101	101	79	0	78.22%
	Urban	512	512	421	0	82.23%
Unknown	2	2	2	0	100.00%	

	Category	Eligible Population	Denominator	NumeratorByAdmin	NumeratorByMedicalRecords	NumeratorBySupplemental	Rate
<b>Cervical Cancer Screening</b>	Total	25,798	411	216	10	14	58.39%
	<b>Race</b>						
	White	10,547	183	90	3	5	53.55
	Black or African American	13,307	198	107	5	6	59.60
	American Indian and Alaska Native	240	6	5	0	1	100.00%
	Asian	357	3	1	0	0	33.33
	Native Hawaiian or Other Pacific Islander	20	1	1	0	0	100.00%
	Some Other Race	0	0	0	0	0	N/A
	Two or More Races	275	3	1	0	0	33.33%
	Asked but No Answer	0	0	0	0	0	N/A
	Unknown	1,052	17	11	2	2	88.24%
	<b>Ethnicity</b>						
	Hispanic or Latino	2,862	54	25	2	4	57.41%
	Not Hispanic or Latino	15,978	250	148	5	3	62.40%
	Declined Ethnicity	0	0	0	0	0	N/A
	Unknown Ethnicity	6,958	107	43	3	7	49.53%
	<b>Geography</b>						
	Rural	7,028	100	51	4	1	56.00%
	Urban	18,548	305	161	6	13	59.02%
	Unknown	222	6	4	0	0	66.67%

**iv. Behavioral Health:** Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Substance Use (within 30 days), Follow-Up After Hospitalization for Mental Illness (within 30 days), Initiation and Engagement of Substance Use Disorder Treatment (IET) (CY 2024)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
<b>Follow-Up After Emergency Department Visit for Mental Illness (within 30 days)</b>	Total	463	463	166	3	36.50%
	<b>Race</b>					
	White	177	177	65	2	37.85%
	Black or African American	262	262	90	1	34.73%
	American Indian and Alaska Native	2	2	0	0	0.00%
	Asian	0	0	0	0	N/A
	Native Hawaiian or Other Pacific Islander	0	0	0	0	N/A
	Some Other Race	0	0	0	0	N/A
	Two or More Races	5	5	4	0	80.00%
	Asked but No Answer	0	0	0	0	N/A
	Unknown	17	17	7	0	41.18%
	<b>Ethnicity</b>					
	Hispanic or Latino	71	71	22	1	32.39%
	Not Hispanic or Latino	286	286	112	2	39.86%
	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	106	106	32	0	30.19%
	<b>Sex</b>					
	Male	240	240	86	2	36.67%
	Female	223	223	80	1	36.32%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	119	119	44	1	37.82%
	Urban	338	338	121	2	36.39%
Unknown	6	6	1	0	16.67%	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
<b>Follow-Up After Emergency Department Visit for Substance Use (within 30 days)</b>	Total	852	852	206	7	25.00%
	<b>Race</b>					
	White	355	355	115	5	33.80%
	Black or African American	439	439	78	1	18.00%
	American Indian and Alaska Native	8	8	1	0	12.50%
	Asian	5	5	1	0	20.00%
Native Hawaiian or Other Pacific Islander	0	0	0	0	N/A	

	Some Other Race	0	0	0	0	N/A	
	Two or More Races	8	8	2	0	25.00%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	37	37	9	1	27.03%	
	<b>Ethnicity</b>						
	Hispanic or Latino	116	116	19	0	16.38%	
	Not Hispanic or Latino	474	474	141	4	30.59%	
	Declined Ethnicity	0	0	0	0	N/A	
	Unknown Ethnicity	262	262	46	3	18.70%	
	<b>Sex</b>						
	Male	523	523	115	4	22.75%	
	Female	329	329	91	3	28.57%	
	Unknown	0	0	0	0	N/A	
	<b>Geography</b>						
	Rural	214	214	53	3	26.17%	
	Urban	631	631	152	4	24.72%	
Unknown	7	7	1	0	14.29%		

	Category	EligiblePopulation	Denominator	NumeratorByAd min	NumeratorBy Supplemental	Rate	
<b>Follow-Up After Hospitalization for Mental Illness (within 30 days)</b>	Total	3,293	3,293	1,234	86	40.09%	
	<b>Race</b>						
	White	1,469	1,469	596	33	42.82%	
	Black or African American	1,580	1,580	551	50	38.04%	
	American Indian and Alaska Native	24	24	12	1	54.17%	
	Asian	13	13	7	0	53.85%	
	Native Hawaiian or Other Pacific Islander	0	0	0	0	N/A	
	Some Other Race	0	0	0	0	N/A	
	Two or More Races	46	46	20	0	43.48%	
	Asked but No Answer	0	0	0	0	N/A	
	Unknown	161	161	48	2	31.06%	
	<b>Ethnicity</b>						
	Hispanic or Latino	465	465	155	11	35.70%	
	Not Hispanic or Latino	1,983	1,983	816	62	44.28%	
	Declined Ethnicity	0	0	0	0	N/A	
	Unknown Ethnicity	845	845	263	13	32.66%	

	<b>Sex</b>					
	Male	1,819	1,819	627	37	36.50%
	Female	1,474	1,474	607	49	44.50%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	881	881	364	24	44.04%
	Urban	2,370	2,370	859	62	38.86%
Unknown	42	42	11	0	26.19%	

	Category	Eligible Population	Denominator	NumeratorByAd min	NumeratorByS upplemental	Rate
<b>Initiation and Engagement of Substance Use Disorder Treatment (IET): Initiation of SUD Treatment</b>	Total	5,560	5,560	2,904	726	65.29%
	<b>Race</b>					
	White	2,646	2,646	1,477	352	69.12%
	Black or African American	2,540	2,540	1,224	327	61.06%
	American Indian and Alaska Native	54	54	26	12	70.37%
	Asian	19	19	6	2	42.11%
	Native Hawaiian or Other Pacific Islander	4	4	2	1	75.00%
	Some Other Race	0	0	0	0	N/A
	Two or More Races	62	62	39	8	75.81%
	Asked but No Answer	0	0	0	0	N/A
	Unknown	235	235	130	24	65.53%
	<b>Ethnicity</b>					
	Hispanic or Latino	750	750	387	105	65.60%
	Not Hispanic or Latino	3,194	3,194	1,667	429	65.62%
	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	1,616	1,616	850	192	64.48%
	<b>Sex</b>					
	Male	3,107	3,107	1,700	375	66.78%
	Female	2,453	2,453	1,204	351	63.39%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	1,529	1,529	741	238	64.03%
	Urban	3,994	3,994	2,133	486	65.57%
	Unknown	37	37	30	2	86.49%

	Category	Eligible Population	Denominator	NumeratorByAd min	NumeratorByS upplemental	Rate
<b>Initiation and Engagement of Substance Use Disorder Treatment (IET): Engagement of SUD Treatment</b>	Total	5,560	5,560	1,600	154	31.55%
	<b>Race</b>					
	White	2,646	2,646	902	84	37.26%
	Black or African American	2,540	2,540	601	60	26.02%
	American Indian and Alaska Native	54	54	17	3	37.04%
	Asian	19	19	1	1	10.53%
	Native Hawaiian or Other Pacific Islander	4	4	2	0	50.00%
	Some Other Race	0	0	0	0	N/A
	Two or More Races	62	62	24	0	38.71%
	Asked but No Answer	0	0	0	0	N/A
	Unknown	235	235	53	6	25.11%
	<b>Ethnicity</b>					
	Hispanic or Latino	750	750	230	20	33.33%
	Not Hispanic or Latino	3,194	3,194	921	90	31.65%
	Declined Ethnicity	0	0	0	0	N/A
	Unknown Ethnicity	1,616	1,616	449	44	30.51%
	<b>Sex</b>					
	Male	3,107	3,107	952	95	33.70%
	Female	2,453	2,453	648	59	28.82%
	Unknown	0	0	0	0	N/A
	<b>Geography</b>					
	Rural	1,529	1,529	442	55	32.50%
	Urban	3,994	3,994	1,144	97	31.07%
	Unknown	37	37	14	2	43.24%

Please share other comments/observations on your Health Equity progress since the submission of the MCO

**3.0 Health Equity Plan:** ACLA has made progress in integrating Health Equity within our organization and executing opportunities to provide care that meets the cultural needs of our members lived experience and responsive to their cultural needs. Continued efforts will be made to support the inclusive and equitable care generated from the voice of our Enrollees, stakeholders, providers, and communities.