



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

**External Quality Review
Technical Report**

**Aggregate Report for the
Prepaid Ambulatory Health Plans**

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,¹ with further revisions released in November 2020.² The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Louisiana Department of Health (LDH) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

The Louisiana Medicaid Managed Care Program

The day-to-day operations of the Louisiana Medicaid managed care program are the responsibility of the Bureau of Health Services Financing within LDH, with oversight of specialized behavioral health services, 1115 Substance Use Demonstration Waiver, and the Coordinated System of Care (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

¹ Centers for Medicare & Medicaid Services. Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>. Accessed on: Jan 5, 2026.

² Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: <https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care>. Accessed on: Jan 5, 2026.

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 2023.³ 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	✓	✓	✓

³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jan 5, 2026.

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.

		
<h3>Quality</h3> <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.¹</p>	<h3>Timeliness</h3> <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.”² It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).</p>	<h3>Access</h3> <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.¹</p>
<p>¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.</p> <p>² 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 PAHP.

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each PAHP, as well as the program overall. To produce the PAHP aggregate SFY 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 PAHPs:

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

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

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

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

Louisiana's Medicaid Managed Care Quality Strategy

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

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

Goals and Objectives

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

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



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

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

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



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

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

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



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

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation⁴

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 Louisiana Medicaid members. LDH plans to incorporate goals from the National Quality Strategy in the

⁴ 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. Accessed on: Jan 5, 2026.

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"> • Ensure appropriate hospice onboarding and transitioning from palliative care to hospice. • Promote early initiation of palliative care to improve quality of life. • Promote health development and wellness in children and adolescents. • Advance specific interventions to address social determinants of health (SDOH). • Advance value-based payment arrangements and innovation. • Ensure members who are improving or stabilized in hospice are considered for discharge. 	<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 measures</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
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"> • <i>Enrollment by Product Line</i> • <i>Language Diversity of Membership</i> • <i>Race/Ethnicity Diversity of Membership</i> 	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 aggregated results of all EQR-related activities for the two PAHPs that serve as Louisiana Medicaid's dental benefit program managers (DBPMs), DentaQuest USA Insurance Company (DentaQuest) (DQ) and Managed Care North America (MCNA), conducted with Louisiana Medicaid managed care throughout SFY 2025.

Validation of Performance Improvement Projects

The PAHPs 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 the PAHPs to conduct PIPs on the following state-mandated topics during SFY 2025:

- *Increase the Percentage of EPSDT [Early and Periodic Screening, Diagnostic and Treatment] Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service*
- *Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday*

Validation of Performance Measures

For SFY 2025, HSAG administered an Information Systems Capabilities Assessment (ISCA) to the PAHPs to assess their information systems (IS) and data processes. HSAG's review of the ISCA completed by the PAHPs found that both MCNA and DQ met the requirement of maintaining IS that collect, analyze, integrate, and report data that comply with LDH and federal reporting requirements. Both PAHPs' rates on *The percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 1-20, receiving at least 1 preventative dental service (CMS-416 Line 12b)* performance measure increased from the previous reporting period, indicating that the PAHPs have taken steps to improve members' access to preventative dental services. Additionally, both PAHPs' rates on the *Oral Evaluation, Dental Services (OED)* performance measure exceeded the goal established by LDH for 2025, demonstrating that members enrolled with the PAHPs received an oral examination as frequently as intended by LDH. Despite the year-on-year improvement on the *CMS-416 Line 12b* measure, both PAHPs' rates fell below the 2025 goal established by LDH for this measure, indicating opportunities for continued improvement in ensuring members' access to preventive dental services.

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 PAHPs 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	DQ CY 2024	MCNA CY 2024	PAHP Average Results
I	Enrollment and Disenrollment Requirements and Limitations	78%	100%	89%
II	Member Rights and Confidentiality	88%	100%	94%
III	Member Information	56%	82%	70%
IV	Emergency and Poststabilization Services	54%	100%	77%
V	Adequate Capacity and Availability of Services	8%	62%	36%
VI	Coordination and Continuity of Care	92%	92%	92%
VII	Coverage and Authorization of Services	95%	85%	90%
VIII	Provider Selection	73%	100%	87%
IX	Subcontractual Relationships and Delegation	40%	40%	40%
X	Practice Guidelines	0%	100%	50%
XI	Health Information Systems	100%	100%	100%
XII	Quality Assessment and Performance Improvement	91%	100%	95%
XIII	Grievance and Appeal Systems	76%	84%	80%
XIV	Program Integrity	83%	100%	92%
Total Compliance Score		72%	90%	

Validation of Network Adequacy

For time and distance indicators, results were assessed for CY 2024. Compliance thresholds were met across both dental PAHPs for the general dentist, oral surgeon, and orthodontist provider types. However, as noted in Table 1-5, neither dental PAHP met either of the indicator thresholds of access for members for the periodontist or prosthodontist provider types, or the indicator threshold regarding compliance expected for all members for the endodontist provider type.

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

Provider Type	Indicator	Percentage of Members With Access DQ	Percentage of Members With Access MCNA
Endodontist	No more than 75 miles for all members, as determined from the member’s place of residence	87.50%	71.80%
Periodontist	No more than 60 miles for 75 percent of members, as determined from the member’s place of residence	55.00%	53.70%
	No more than 75 miles for all members, as determined from the member’s place of residence	63.30%	61.40%
Prosthodontist	No more than 60 miles for 75 percent of members, as determined from the member’s place of residence	72.70%	64.30%
	No more than 75 miles for all members, as determined from the member’s place of residence	74.60%	74.50%

Encounter Data Validation

Information Systems Review

The IS review provides self-reported qualitative information from the PAHPs about their encounter data processes. Table 1-6 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 1-6—Summary of Strengths and Weaknesses From IS Review

IS Review	DQ	MCNA
Encounter Data Sources and Systems	—	—
Payment Structures	—	—
Encounter Data Quality Monitoring		
Quality Monitoring on Encounters Collected by PAHPs	X	X
% of Encounters Initially Rejected and Not Yet Accepted by LDH	X	√

Administrative Profile

The administrative profile analyzes LDH’s encounter data 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 1-7 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.

Table 1-7—Summary of Strengths and Weaknesses From Administrative Profile

Administrative Profile	DQ	MCNA
Encounter Data Completeness		
Monthly Encounter Volume per 1,000 MM	—	—
Monthly Payment Amount PMPM	—	—
TPL Payment Amount PMPM	—	—
% of Duplicate Encounters	√	√
Encounter Data Timeliness		
Lag Between PAHP Payment Date and Received Date by LDH	—	√
Field-Level Completeness and Accuracy		
% Present	—	—
% Valid	X	√

Administrative Profile	DQ	MCNA
Encounter Referential Integrity		
Dental Encounter vs Enrollment	—	—
Dental Encounter vs Provider	✓	✓
Encounter Data Logic		
% of Members Who Had an Encounter	—	—
Member Enrollment Continuity	—	—

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

CAHPS Dental Survey

HSAG compared the PAHPs’ 2024 top-box scores. These were compared to each other to determine whether there were statistically significant differences. Overall, MCNA’s 2024 adult top-box scores were statistically significantly higher than DQ’s 2024 top-box scores for *Rating of All Dental Care*, *Rating of Dental Plan*, *Access to Dental Care*, *Dental Plan Information and Services*, and *Would Recommend Dental Plan*.

2. Validation of Performance Improvement Projects

Aggregate Results

During SFY 2025 (review period), the PAHPs submitted two new PIPs, initiated in SFY 2024, for initial validation. The PAHPs reported baseline performance indicator results from CY 2024, in January 2025. Table 2-1 summarizes the PIP topics carried out by both PAHPs.

Table 2-1—SFY 2025 PAHP PIP Topics

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

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

Table 2-2—SFY 2025 PAHP PIP Activities

PIP Activities and Milestones	Dates
The PAHPs submitted signed copies of the statewide PIP charters, outlining statewide project designs, identified barriers, and initial improvement strategies	January 2025
The PAHPs submitted draft PIP reports to HSAG for validation	January 2025
HSAG provided draft PIP report validation findings to the PAHPs	February 2025
The PAHPs submitted final PIP reports to HSAG for validation	March 2025
HSAG provided final PIP validation reports to the PAHPs	April 2025

In SFY 2026, the PAHPs will submit the draft PIP reports, including Remeasurement 1 performance indicator results and intervention results, for initial validation in January 2026 and the final PIP reports for final validation in March 2026. HSAG will complete the second annual validation of the PAHP PIPs in April 2026, and the validation findings will be included in next year’s EQR technical report.

Validation Results and Confidence Ratings

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

Table 2-3—SFY 2025 PIP Validation Results for Each PAHP

PAHP	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> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Level ³	Percentage Score of Evaluation Elements <i>Met</i> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Level ³
DQ	<i>Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service</i>	100%	100%	<i>High Confidence</i>	<i>Not Assessed</i> ⁴		
	<i>Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday</i>	100%	100%	<i>High Confidence</i>	<i>Not Assessed</i> ⁴		
MCNA	<i>Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service</i>	100%	100%	<i>High Confidence</i>	<i>Not Assessed</i> ⁴		
	<i>Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday</i>	100%	100%	<i>High Confidence</i>	<i>Not Assessed</i> ⁴		

¹ **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*).

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

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

⁴ **Not Assessed**—HSAG did not assess Validation Rating 2 as the PAHP reported the baseline data for each PIP.

Performance Indicator Results

Table 2-4 displays data for DQ’s *Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service* PIP.

For Table 2-4 through Table 2-7, gray shaded cells with an — represent data that will be updated in future remeasurement years.

Table 2-4—Performance Indicator Results for DQ’s *Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service* 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	D					
The percentage of eligible enrollees 1 to 20 years of age who had at least one preventative dental service during the measurement year.	N: 181,515	44.7%	—	—	—	—	Not Assessed
	D: 405,938		—		—		

N–Numerator D–Denominator

Note: Performance indicator results for each measurement period are based on data reported by the PAHP for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the PAHP for other purposes.

Table 2-5 displays data for MCNA’s *Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service* PIP.

Table 2-5—Performance Indicator Results for MCNA’s *Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service* 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	D					
The percentage of eligible enrollees 1 to 20 years of age who had at least one preventative dental service during the measurement year.	N: 187,604	48.1%	—	—	—	—	Not Assessed
	D: 390,372		—		—		

N–Numerator D–Denominator

Note: Performance indicator results for each measurement period are based on data reported by the PAHP for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the PAHP for other purposes.

Table 2-6 displays data for DQ’s *Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday* PIP.

Table 2-6—Performance Indicator Results for DQ’s *Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday* 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	D					
The percentage of enrollees one year of age who receive a dental visit by their first birthday.	N: 571	4.4%	—	—	—	—	<i>Not Assessed</i>
	D: 13,119		—		—		

N–Numerator D–Denominator

Note: Performance indicator results for each measurement period are based on data reported by the PAHP for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the PAHP for other purposes.

Table 2-7 displays data for MCNA’s *Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday* PIP.

Table 2-7—Performance Indicator Results for MCNA’s *Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday* 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	D					
The percentage of enrollees one year of age who receive a dental visit by their first birthday.	N: 830	4.9%	—	—	—	—	<i>Not Assessed</i>
	D: 16,948		—		—		

N–Numerator D–Denominator

Note: Performance indicator results for each measurement period are based on data reported by the PAHP for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the PAHP for other purposes.

Interventions

Both PAHPs contributed to the development of statewide PIP charters for the two PIP topics. The PIP charters were approved by LDH and signed by each PAHP in January 2025. Table 2-8 summarizes the barriers and interventions identified in the statewide PAHP PIP charters signed by both PAHPs.

Table 2-8—Statewide Barriers and Interventions Identified in the PIP Charter for Each PIP Topic

PIP Topic	Barriers	Interventions
<p><i>Increase the Percentage of EPSDT Enrollees (Enrolled for at Least 90 Consecutive Days), Age 1–20, Receiving at Least 1 Preventative Dental Service</i></p>	<ul style="list-style-type: none"> • Access to Care: Enrollee/guardian does not have a dental provider or unable to find a provider. • Lack of oral health literacy and limited provider or non-robust reminder system. • Enrollees not returning for recall visits and/or following their treatment plan. • Providers limited or a non-robust reminder system with the administrative burden of filling out a form to report missed appointments. • Lack of oral health literacy. 	<ul style="list-style-type: none"> • Enrollee assigned to dental provider and informed of their assigned provider and contact information. • Preventive Care Postcards: Postcards sent monthly to enrollees due for a preventive checkup. • Use Current Dental Terminology (CDT) procedure code D9986 (missed appointment) to track missed appointments and follow up with members to address barriers to attending scheduled appointments. • Preventive Care Outbound Call Campaign—Contact enrollees overdue for preventive care and provide oral health education and appointment scheduling assistance.
<p><i>Increase the Rate of Children Receiving an Annual Dental Visit by Their First Birthday</i></p>	<ul style="list-style-type: none"> • Limited oral health literacy. • Parent/guardian of enrollee unaware of the importance of having a dental visit by the age of one. • Parent/guardian of enrollee unaware infant has dental benefits. 	<ul style="list-style-type: none"> • Educational outreach to parent/guardian on importance of scheduling a dental visit no later than age of one. • Welcome call informing parent/guardian of dental benefits and importance of scheduling appointment. • Baby’s First Toothbrush Kit Mailing—At 10 months of age, enrollees will receive a baby toothbrush, oral health flyer, and letter educating the parent/guardian regarding the importance of the child receiving their first dental checkup by the first birthday. • A postcard is sent to enrollees at 9 months of age to educate parents/guardian on the importance of oral health and inform them that the first dental visit should take place after the first tooth appears but no later than the child’s first birthday.

For the SFY 2026 PIP validation, the PAHPs will report PAHP-specific Remeasurement 1 updates to the barriers and interventions. HSAG will complete the assessment of each PAHP's Remeasurement 1 QI activities and interventions in SFY 2026, and HSAG's validation findings will be reported in next year's EQR technical report.

Statewide PAHP Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs statewide, the following strengths were identified:

- The PAHPs developed and carried out a methodologically sound design for both PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The PAHPs conducted and reported accurate analyses and interpretation of performance indicator results for both PIPs. **[Quality]**
- The PAHPs used appropriate QI science-based tools and processes to identify PAHP-specific barriers to improvement and identified interventions to address identified barriers for both PIPs. **[Quality]**

For the PAHPs statewide, based on the SFY 2025 PIP validation findings, HSAG did not identify any opportunities for improvement or recommendations. Both PAHPs received *Met* scores for all applicable evaluation elements and received a validation rating of *High Confidence* for each PIP.

Methodology

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

Objectives

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

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

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

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

Technical Methods of Data Collection

HSAG, as the State’s EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).⁵

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

1. HSAG evaluates the technical structure of the PIP to ensure that the PAHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG’s review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound

⁵ 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: Jan 5, 2026.

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

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

In alignment with the CMS EQR Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the PAHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. The PAHP will be assessed for the second validation rating in SFY 2026. 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 PAHP. HSAG then identified common themes and the salient patterns that emerged across the PAHPs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

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

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the PAHPs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of a PAHP’s PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the PAHP’s process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-9.

Table 2-9—Assignment of PIPs to the Quality, Timeliness, and Access Domains

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

3. Validation of Performance Measures

Aggregate Results

Information Systems Capabilities Assessment

In 2025, HSAG administered an ISCA to the PAHPs to assess their IS and data processes. HSAG’s review of the results found that both MCNA and DQ met the requirement of maintaining IS that collect, analyze, integrate, and report data that comply with LDH and federal reporting requirements. The systems also provided information on utilization, grievances, and appeals. The review comprised the following areas:

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

In 2025, LDH worked with the University of Louisiana at Monroe (ULM) to calculate rates on the *CMS-416 Line 12b* measure based on data collected by the PAHPs during federal fiscal year (FFY) 2024 (October 1, 2023–September 30, 2024), and calculate rates on the *OED* measure based on data collected by the PAHPs during CY 2024 (January 1, 2024–December 31, 2024).

Performance Measures

Table 3-1 displays performance measure definitions, stewards, reporting periods, goals, and PAHP performance measure rates for the PAHPs. Both PAHPs improved their performance on the *CMS-416 Line 12b* measure based on rates calculated in 2025 compared to rates calculated in 2024; however, the PAHPs’ rates on this measure fell below the LDH-established goal for measurement year (MY) 2024. The PAHPs’ performance on the *OED* measure, based on rates calculated in 2025, exceeded the LDH-established goal for MY 2024.

Table 3-1—PAHP Performance Measures

Measure	Steward	Reporting Period	Goal (MY 2024)	MCNA Rate			DQ Rate		
				MY 2022	MY 2023	MY 2024	MY 2022	MY 2023	MY 2024
<i>The Percentage of EPSDT Enrollees (Enrolled For at Least 90 Consecutive Days), Age 1-20,</i>	CMS	March 2025	48.63%	44.63%	45.36%	47.27%	41.53%	42.89%	45.23%

Measure	Steward	Reporting Period	Goal (MY 2024)	MCNA Rate			DQ Rate		
				MY 2022	MY 2023	MY 2024	MY 2022	MY 2023	MY 2024
Receiving at Least 1 Preventative Dental Service (CMS-416 Line 12b)									
Oral Evaluation, Dental Services (OED)	NCQA	June 2025	48.23%	—	—	51.62%	—	—	48.69%

— indicates that OED measure rates were not calculated for the PAHPs for MY 2022 and MY 2023.

Statewide PAHP Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs statewide, the following strengths were identified:

- Both PAHPs’ rates on the *CMS-416 Line 12b* performance measure increased from the prior reporting period (i.e., 2024), indicating that the PAHPs took steps to improve members’ access to preventive dental services. **[Quality, Timeliness, and Access]**
- Both PAHPs rates on the *OED* performance measure exceeded the goal established by LDH for 2025, demonstrating that members enrolled with the PAHPs received an oral evaluation as frequently as intended by LDH. **[Quality, Timeliness, and Access]**

For the PAHPs statewide, the following opportunity for improvement was identified:

- Both PAHPs’ rates on the *CMS-416 Line 12b* performance measure fell below the LDH-established goal for the 2025 reporting period, suggesting that fewer than anticipated Medicaid members ages 1 to 20 years received a preventive dental service during the measurement period (i.e., October 1, 2023, to September 30, 2024). **[Quality, Timeliness, and Access]**

For the PAHPs statewide, the following recommendation was identified:

- HSAG recommends that the PAHPs work with dental service providers to ensure that Medicaid members have access to preventive service from “infancy and continuing to adolescence and beyond,” as recommended by the American Academy of Pediatric Dentistry.⁶ The PAHPs should educate Medicaid members about the importance of receiving preventive dental services and should consider targeted interventions based on identified disparities through ongoing data analysis and

⁶ American Academy of Pediatric Dentistry. Periodicity of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment of infants, children, and adolescents. Available at: https://www.aapd.org/globalassets/media/policies_guidelines/bp_periodicity.pdf. Accessed on: Jan 5, 2026.

stratification across key demographics such as race, ethnicity, age, and ZIP Code. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

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

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

Technical Methods of Data Collection

LDH selected performance measures to evaluate the quality of care delivered by the PAHPs to Louisiana Medicaid members. The *CMS-416 Line 12b* measure assessed the effectiveness of the State's EPSDT program by examining the percentage of Medicaid-eligible individuals under 21 years of age who received health screenings and preventive health services, were referred for corrective treatment, and received dental treatment. The *OED* measure assessed the effectiveness of the PAHPs' efforts to monitor the health of members and prevent disease by examining the percentage of Medicaid-eligible individuals under 21 years of age who received a comprehensive or periodic oral evaluation during the measurement year. LDH reported multiple performance measures for the dental program, *CMS-416 Line 12b* and *OED*.

LDH utilized a contractor who produces the performance measures instead of the PAHPs self-reporting. The contractor produced rates for the *CMS-416 Line 12b* and *OED* measures.

Description of Data Obtained

HSAG obtained a copy of the *CMS-416 Line 12b* and *OED* information from LDH. Data were reported for the *CMS-416 Line 12b* measure, which determines the percentage of children and adolescents receiving preventive dental services, and the *OED* measure, which determines the percentage of children and adolescents receiving a comprehensive or period oral evaluation with a dental provider during the measurement year.

How Data Were Aggregated and Analyzed

For SFY 2025, HSAG administered an ISCA to the PAHPs to assess their IS and data processes. The review comprised the following areas:

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

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each PAHP provided to members, HSAG evaluated the results for each performance measure based on the LDH target to identify strengths and opportunities for improvement and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each opportunity for improvement, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the PAHP’s Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid PAHPs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-2.

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

Performance Measure	Quality	Timeliness	Access
<i>The percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 1-20, receiving at least 1 preventative dental service (CMS-416 Line 12b)</i>	✓	✓	✓
<i>Oral Evaluation, Dental Services (OED)</i>	✓	✓	✓

4. Assessment of Compliance With Medicaid Managed Care Regulations

Aggregate Results

Table 4-1 and Table 4-2 present an overview of the results of the 2025 CR for DQ and MCNA. 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—DQ 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	7	2	3	78%
II	Member Rights and Confidentiality	24	24	21	3	0	88%
III	Member Information	19	16	9	7	3	56%
IV	Emergency and Poststabilization Services	13	13	7	6	0	54%
V	Adequate Capacity and Availability of Services	15	12	1	11	3	8%
VI	Coordination and Continuity of Care	12	12	11	1	0	92%
VII	Coverage and Authorization of Services	23	20	19	1	3	95%
VIII	Provider Selection	19	15	11	4	4	73%
IX	Subcontractual Relationships and Delegation	6	5	2	3	1	40%
X	Practice Guidelines	6	6	0	6	0	0%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	10	1	2	91%
XIII	Grievance and Appeal Systems	38	37	28	9	1	76%
XIV	Program Integrity	18	18	15	3	0	83%
Total Compliance Score		227	207	150	57	20	72%

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.

Table 4-2—MCNA Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	NM	NA	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	9	0	3	100%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	17	14	3	2	82%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	13	8	5	2	62%
VI	Coordination and Continuity of Care	12	12	11	1	0	92%
VII	Coverage and Authorization of Services	23	20	17	3	3	85%
VIII	Provider Selection	19	15	15	0	4	100%
IX	Subcontractual Relationships and Delegation	6	5	2	3	1	40%
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	31	6	1	84%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		227	209	188	21	18	90%

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.

Statewide PAHP Strengths, Opportunities for Improvement, Required Actions, and/or Recommendations

For the PAHPs statewide, the following strengths were identified:

- The PAHPs received high compliance scores for Standard VI—Coordination and Continuity of Care, demonstrating that the PAHPs collaborated with the MCEs to assess members’ needs and coordinate care. **[Quality]**

- The PAHPs achieved a 100 percent compliance score for Standard XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]**
- The PAHPs received high compliance scores for Standard XII—Quality Assessment and Performance Improvement, demonstrating that the PAHPs had comprehensive policies, systematic monitoring, and ongoing program evaluation consistent with federal and contractual standards. **[Quality]**

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

- DQ’s CR demonstrated low compliance (below 60 percent) for five of 15 standards. **[Quality, Timeliness, and Access]**
- The PAHPs did not ensure that all member handbooks include all required components. **[Quality]**
- Neither PAHP included the required information in the provider directory. **[Quality and Access]**
- The PAHPs’ websites 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 PAHP provides it upon request within five business days. **[Quality]**
- The PAHPs did not monitor their provider networks 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]**
- The PAHPs did not require network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality, Timeliness, and Access]**
- The PAHPs did not ensure its network providers offer office hours at least equal to those offered by commercial dental insurance plans. **[Quality, Timeliness, and Access]**
- The PAHPs did not ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- The PAHPs did not ensure that the adverse benefit determination (ABD) notification process includes reading grade-level verification and that ABD notices meet the state-required reading level. **[Quality]**
- Neither PAHP ensured that all contracts or written arrangements comply—and that all delegates agreed 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]**
- Neither PAHP included required provisions ensuring federal and State audit access to all delegate records, systems, and facilities—including downstream entities—for up to 10 years after contract termination. **[Quality]**
- The case file review for both PAHPs indicated noncompliance with resolution notice requirements. **[Quality]**

- Neither PAHP demonstrated full compliance with requirements regarding members filing an appeal orally or in writing; with the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. **[Quality and Timeliness]**

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

- The PAHPs must ensure that all member handbooks include all required components. **[Quality]**
- The PAHPs must include all required components in the provider directory. **[Quality and Access]**
- The PAHPs' websites 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]**
- The PAHPs must monitor, through the collection and analysis of data, their provider networks to ensure adequate access to all services for all members, including those with limited English proficiency or physical or mental disabilities. **[Quality]**
- The PAHPs must meet and require their network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality, Timeliness, and Access]**
- The PAHPs must ensure its network providers offer office hours at least equal to those offered by commercial dental insurance plans. **[Quality, Timeliness, and Access]**
- The PAHPs must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- The PAHPs must ensure that the ABD notification process includes reading grade-level verification, and that ABD notices meet the state-required reading level. The PAHPs should add functionality to the system that houses and tracks prior authorization requests and resolutions so users may document that ABD notices include all requirements and indicate that the reading grade level has been verified. **[Quality]**
- The PAHPs must ensure that all 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]**
- The PAHPs must ensure all subcontractor agreements include full federal and State audit rights—covering all records, systems, premises, and downstream entities, including fraud-related audits—with access maintained for at least 10 years. **[Quality]**
- The PAHPs must ensure that grievance resolution letters are dated and sent to the member no later than 90 calendar days from the date the PAHP receives the grievance. **[Quality]**
- DQ must develop and maintain a member consent form template. MCNA must revise the Adult Denture Program member handbook and the EPSDT member handbook to remove the requirement that a verbal appeal must be followed up in writing. **[Quality and Timeliness]**

Methodology

Activity 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 Part438. 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 4-3 outlines the division of standards reviewed in CY 2021, CY 2022, CY 2023, and CY 2024.

Table 4-3—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	✓	✓	✓				-	✓	✓	✓

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

* 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 and Analysis

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).⁷

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 a review of delegation records.
- 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.

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.

⁷ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jan 5, 2026.

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 4-4 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 4-4—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 PAHP personnel, and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

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

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

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

How Conclusions Were Drawn

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

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

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

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment 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

Aggregate Results

NAV Audit

This section presents the results from the CY 2025 (review period) NAV audit.

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 PAHP’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 PAHP according to the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4)⁸ and as defined in Table 5-4 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 5-1 presents a summary of the NAV validation ratings for both PAHPs by network adequacy standard type.

Table 5-1—Summary of Both PAHP 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%

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

For time and distance indicators, compliance thresholds were met across both dental PAHPs for the general dentist, oral surgeon, and orthodontist provider types. However, as noted in Table 5-2, neither dental PAHP met either of the indicator thresholds of access for members for the periodontist or prosthodontist provider types, or the indicator threshold regarding compliance expected for all members for the endodontist provider type.

⁸ 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: Jan 5, 2026.

Table 5-2—Provider Types That Fell Below the Required Threshold Across Both Dental PAHPs, by Indicator

Provider Type	Indicator	Percentage of Members With Access DQ	Percentage of Members With Access MCNA
Endodontist	No more than 75 miles for all members, as determined from the member’s place of residence	87.50%	71.80%
Periodontist	No more than 60 miles for 75 percent of members, as determined from the member’s place of residence	55.00%	53.70%
	No more than 75 miles for all members, as determined from the member’s place of residence	63.30%	61.40%
Prosthodontist	No more than 60 miles for 75 percent of members, as determined from the member’s place of residence	72.70%	64.30%
	No more than 75 miles for all members, as determined from the member’s place of residence	74.60%	74.50%

Statewide PAHP Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs statewide, the following strengths were identified:

- High levels of member access were reported for the provider types of general dentist, oral surgeon, and orthodontist. **[Quality, Timeliness, and Access]**
- Overall, the PAHPs had well-defined processes and procedures in place to ensure the efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. **[Quality, Timeliness, and Access]**

For the PAHPs statewide, the following opportunity for improvement was identified:

- For the PAHPs, access for the provider type of periodontist within 75 miles was not available for at least 35 percent of members, and access for the provider type of prosthodontist within 75 miles was not available for at least 25 percent of members. **[Quality, Timeliness, and Access]**

For the PAHPs statewide, the following recommendation was identified:

- HSAG recommends that LDH and the PAHPs collaborate to identify barriers to care and what steps may be taken to assist in improving access for members to these specialty dental provider types. **[Quality, Timeliness, and Access]**

Methodology

Objectives

In accordance with 42 CFR §438.350(a) states that contract with MCOs, PIHPs, and PAHPs, collectively referred to as “MCEs,” to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

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

Technical Methods of Data Collection

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

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

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

Description of Data Obtained

HSAG prepared a document request packet that was submitted to each PAHP outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG’s ability to assess each PAHP’s IS and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the PAHPs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the PAHPs to conduct the NAV audits:

- IS data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Data Were Aggregated and Analyzed

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

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

How Conclusions Were Drawn

HSAG calculated each network adequacy indicator’s validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 5-3.

Table 5-3—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 PAHP’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG’s overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 5-4 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-4—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 PAHP provide a root cause analysis of the finding.
- Working with the PAHP to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG’s NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG’s NAV Oversight Review Committee based on the following threshold:
 - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

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

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

Table 5-5—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

Aggregate Results

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

Table 6-1—EDV Results for the PAHPs

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	<ul style="list-style-type: none"> Both PAHPs 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. Both PAHPs reported methods to identify duplicate claims. Both PAHPs were responsible for the collection and maintenance of the provider information. In addition, both PAHPs integrated the Medicaid member enrollment files into their systems for claim processing.
Payment Structures	<ul style="list-style-type: none"> DQ reported a line-by-line pricing methodology for its dental encounters, while MCNA paid its dental claims at the Medicaid-approved fee schedule based on the service provided. Both PAHPs collected and verified TPL information, processed payments based on TPL information, and submitted TPL information to LDH via the encounter data.

Analysis	Key Findings
Encounter Data Quality Monitoring	<ul style="list-style-type: none"> For encounters collected by the PAHPs, both PAHPs noted that they performed only claim volume check. Based on the PAHPs' responses to the questionnaire, the percentage of dental encounters that were initially rejected and not yet accepted by LDH were 5.8 percent and 0.9 percent for DQ and MCNA, respectively.
Administrative Profile	
Encounter Data Completeness	<ul style="list-style-type: none"> Both PAHPs displayed consistent encounter volume per 1,000 MM, payment amount PMPM, and TPL payment amount PMPM for dental encounters throughout the measurement year. Both PAHPs had a rate of duplicate dental encounters of less than 0.1 percent.
Encounter Data Timeliness	<ul style="list-style-type: none"> Within 60 days, DQ submitted 92.9 percent and MCNA submitted 98.4 percent of dental encounters to LDH after the payment date.
Field-Level Completeness and Accuracy	<ul style="list-style-type: none"> All key data elements in both PAHPs' encounter data had a relatively high or reasonable rate of population (i.e., percent present). While DQ had one data element with an accuracy rate below 95.0 percent for its dental encounters, MCNA had all key data elements populated with at least 95.0 percent of valid values. Refer to the opportunities for improvement section below for the data element needing DQ's attention.
Encounter Referential Integrity	<ul style="list-style-type: none"> No major concerns were noted for both PAHPs when evaluating the integrity between dental encounters and member enrollment data. Of all identified National Provider Identifiers (NPIs) in DQ's and MCNA's submitted dental encounters, 97.9 percent and 99.9 percent were identified in the provider data, respectively.
Encounter Data Logic	<ul style="list-style-type: none"> DQ and MCNA had 20.9 percent and 21.7 percent of members with dental encounters throughout the measurement year, respectively. DQ and MCNA had 74.3 percent and 77.0 percent of members who were continuously enrolled in the measurement year, respectively.

Statewide PAHP Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs statewide, the following strengths were identified:

- MCNA reported less than 1.0 percent of dental encounters as initially rejected and not yet accepted. **[Quality]**
- Less than 0.1 percent of dental encounters were duplicates for both PAHPs. **[Quality]**
- MCNA submitted 98.4 percent of dental encounters to LDH within 60 days. **[Timeliness]**
- For dental encounters, MCNA had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**
- For referential integrity, DQ and MCNA had 97.9 percent and 99.9 percent of providers in the dental data that were found in the provider data, respectively. **[Quality]**

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

- Neither PAHP reported performing completeness and accuracy, timeliness, or reconciliation with financial reports checks on their dental encounters. **[Quality and Timeliness]**
- DQ had 5.8 percent of dental encounters classified as encounters initially rejected and not yet accepted by LDH. **[Quality]**
- DQ had the following data element with less than 95.0 percent of valid values: **[Quality]**
 - Dental Encounters: *Rendering Provider NPI* (91.5 percent)

For the PAHPs statewide, the following recommendations were identified:

- Both PAHPs should build additional encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of their dental encounter data. **[Quality and Timeliness]**
- DQ should build a process with LDH to ensure that rejected dental encounters will be submitted to LDH with correct information. **[Quality]**
- DQ 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]**

Methodology

Objective

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).⁹
- 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

⁹ 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: Jan 5, 2026.

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 billing provider NPI values in the *Billing Provider NPI* 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 listed below. 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 sub-population. 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
Percent Present: 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.
Percent Valid: 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	837D Encounters	Criteria for Validity
Member ID ^H	✓	<ul style="list-style-type: none"> In member file Enrolled in a specific MCE on the date of service
Detail Service From Date ^D	✓	<ul style="list-style-type: none"> Detail Service From Date ≤ Detail Service To Date Detail Service From Date ≤ Paid Date
Detail Service To Date ^D	✓	<ul style="list-style-type: none"> Detail Service To Date ≥ Detail Service From Date Detail Service To Date ≤ Paid Date
Billing Provider National Provider Identifier (NPI) ^H	✓	<ul style="list-style-type: none"> In provider data when service occurred Meets Luhn formula requirements
Rendering Provider NPI ^H	✓	<ul style="list-style-type: none"> In provider data when service occurred Meets Luhn check digit formula requirements
Referring Provider NPI ^H	✓	<ul style="list-style-type: none"> In provider data when service occurred Meets Luhn check digit formula requirements
Rendering Provider Taxonomy Code ^H	✓	<ul style="list-style-type: none"> In standard taxonomy code set Matches the value in provider data
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Codes/Current	✓	In national CPT, HCPCS, CDT code sets for the correct code year (e.g., in 2023 code set for services that occurred in 2023)

Key Data Elements	837D Encounters	Criteria for Validity
Dental Terminology (CDT) Codes ^D		
Tooth Number ^D	✓	In national standard code set
Tooth Surface ^D	✓	In national standard code set
Oral Cavity Code ^D	✓	In national standard code set
Submit Date ^D	✓	MCE Submission Date (i.e., the date when the MCE submits encounters to LDH) ≥ MCE Paid Date
MCE Paid Date ^D	✓	MCE Submission Date (i.e., the date when MCE submit encounters to LDH) ≥ MCE Paid Date
Detail Paid Amount ^D	✓	Zero or positive
Detail TPL Paid Amount ^D	✓	Zero or positive

^H Conduct evaluation at the header level.

^D 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., rendering provider NPI and billing provider NPI on a dental encounter), HSAG included both unique NPIs in the analysis.

Table 6-4—Key Indicators of Referential Integrity

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

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 dental encounter, or without any dental encounters from January 1, 2023, through December 31, 2023, for the dates of service.
- 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. CAHPS Dental Survey

Results

Table 7-1 presents the 2024 adult top-box scores for DQ and MCNA.

Table 7-1—Adult PAHP Results

Measure	DQ	MCNA
<i>Rating of Regular Dentist</i>	61.29% ⁺	77.62%
<i>Rating of All Dental Care</i>	51.16% [↓] ⁺	70.87% [↑]
<i>Rating of Finding a Dentist</i>	25.00% ⁺	47.22% ⁺
<i>Rating of Dental Plan</i>	29.27% [↓] ⁺	56.93% [↑]
<i>Care from Dentists and Staff</i>	85.62% ⁺	93.29%
<i>Access to Dental Care</i>	51.59% [↓] ⁺	67.70% [↑]
<i>Dental Plan Information and Services</i>	58.54% [↓] ⁺	76.99% [↑] ⁺
<i>Would Recommend Dental Plan</i>	63.41% [↓] ⁺	87.13% [↑]

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

[↑] Indicates the 2024 PAHP's score is statistically significantly higher than the comparative PAHP's score.

[↓] Indicates the 2024 PAHP's score is statistically significantly lower than the comparative PAHP's score.

Table 7-2 presents the 2024 child top-box scores for DQ and MCNA.

Table 7-2—Child PAHP Results

Measure	DQ	MCNA
<i>Rating of Regular Dentist</i>	79.71%	80.97%
<i>Rating of All Dental Care</i>	79.14%	82.51%
<i>Rating of Finding a Dentist</i>	61.54% ⁺	62.50% ⁺
<i>Rating of Dental Plan</i>	72.52%	74.77%
<i>Care from Dentists and Staff</i>	96.78%	95.39%
<i>Access to Dental Care</i>	74.90% ⁺	71.50%
<i>Dental Plan Information and Services</i>	94.07% ⁺	90.27% ⁺
<i>Would Recommend Dental Plan</i>	98.48%	98.12%

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

PAHP Strengths, Opportunities for Improvement, and Recommendations

For the PAHPs, the following strengths were identified:

- For the adult population, MCNA’s 2024 top-box scores were statistically significantly higher than DQ’s 2024 top-box scores for the following measures: *Rating of All Dental Care*, *Rating of Dental Plan*, *Access to Dental Care*, *Dental Plan Information and Services*, and *Would Recommend Dental Plan*. **[Quality, Timeliness, and Access]**
- For the child population, MCNA’s 2024 top-box scores were not statistically significantly higher than DQ’s 2024 top-box scores for any measure; therefore, no substantial strengths were identified.

For the PAHPs, the following opportunity for improvement was identified:

- For the adult and child populations, DQ’s 2024 top-box scores were not statistically significantly higher than MCNA’s 2024 top-box scores for any measure. **[Quality, Timeliness, and Access]**

For the PAHPs, the following recommendation was identified:

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

Methodology

Objective

The CAHPS Dental Survey was conducted to collect direct feedback from adult members and parents/caregivers of child members who received dental benefits through one of LDH’s contracted dental plans, DQ and MCNA. The purpose of the survey is to generate actionable performance insights that can help enhance the quality of dental care and services provided to both adult and child members enrolled in one of these plans.

Technical Methods of Data Collection

HSAG administered the adult CAHPS Dental Survey to adult members and a modified version of the adult CAHPS Dental Survey to child members who had a paid or denied dental claim between July 1, 2023, and June 30, 2024. All adult members and parents/caretakers of sampled child members completed the survey from November 2024 to January 2025.

The adult and child CAHPS Dental Survey yielded eight measures that include four global rating measures, three composite measures, and one individual item measure. The global rating measures reflect overall experience with regular dentists, dental care, ease of finding a dentist, and the PAHP. The composite measures are sets of questions grouped together to assess different aspects of dental care (e.g., *Care from Dentists and Staff* and *Access to Dental Care*). The individual item measure is an individual question that asks whether the member or the parents/caretakers of a child member would recommend the PAHP.

For the global ratings, 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 measures, HSAG calculated the percentage of respondents who chose a positive response. The composite measure response choices were “Never,” “Sometimes,” “Usually,” or “Always” and “Definitely No,” “Somewhat No,” “Somewhat Yes,” and “Definitely Yes.” A positive response for the composite measure was a response of “Usually/Always” or “Somewhat Yes/Definitely Yes.”¹⁰ For the individual item measure, HSAG calculated the percentage of respondents who chose a positive response (i.e., “Probably Yes” or “Definitely Yes”).

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.

¹⁰ The exception to this is Question 16 and Question 18 in the *Access to Dental Care* composite measure for the adult and child surveys, respectively, where the response option scale is reversed so responses of “Sometimes/Never” are considered positive responses.

Description of Data Obtained

The CAHPS Dental Survey asked adult members or parents/caretakers of child members to report on and to evaluate their/their child’s experiences with their dental health services. HSAG requested sample frame data files from each PAHP that included, but were not limited to, the following information related to each member of the eligible population: name, gender, date of birth, mailing address, telephone number, race, and ethnicity. HSAG utilized information received in the sample frame data files to conduct the CAHPS Dental Survey.

The CAHPS Dental 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 one question was answered. 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.

How Data Were Aggregated and Analyzed

HSAG performed an analysis of the results in which the PAHPs were compared to each other to determine whether the results were statistically significantly different. Statistically significant differences between the PAHPs were noted with black arrows (↑ or ↓) in the tables. A PAHP denoted with an upward arrow (↑) indicates that the PAHP’s score was statistically significantly higher than the comparative plan. Conversely, a PAHP denoted with a downward arrow (↓) indicates that the PAHP’s score was statistically significantly lower than the comparative plan. A PAHP that did not perform statistically significantly higher or lower than the comparative plan 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 PAHP provided to members, HSAG compared each PAHP’s survey results to each other to determine whether 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 7-1.

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

CAHPS Dental Survey Measure	Quality	Timeliness	Access
<i>Rating of Regular Dentist</i>	✓		
<i>Rating of All Dental Care</i>	✓		
<i>Rating of Finding a Dentist</i>	✓		✓

CAHPS Dental Survey Measure	Quality	Timeliness	Access
<i>Rating of Dental Plan</i>	✓		
<i>Care from Dentists and Staff</i>	✓		
<i>Access to Dental Care</i>	✓	✓	
<i>Dental Plan Information and Services</i>	✓		✓
<i>Would Recommend Dental Plan</i>	✓		

8. PAHP Aggregate Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2025 to comprehensively assess the PAHPs’ performance in providing quality, timely, and accessible healthcare services to Louisiana’s Medicaid and CHIP members. HSAG provides the PAHPs’ aggregate strengths, opportunities for improvement, and recommendations in Table 8-1 through Table 8-3.

Table 8-1—Strengths Related to Quality, Timeliness, and Access

Overall PAHP Strengths	
PIP	<ul style="list-style-type: none"> The PAHPs developed and carried out a methodologically sound design for both PIPs that facilitated valid and reliable measurement of objective indicator performance over time. [Quality] The PAHPs conducted and reported accurate analyses and interpretation of performance indicator results for both PIPs. [Quality] The PAHPs used appropriate QI science-based tools and processes to identify PAHP-specific barriers to improve and identify interventions to address identified barriers for both PIPs. [Quality]
PMV	<ul style="list-style-type: none"> Both PAHPs’ performance measure results increased, indicating that the PAHPs took steps to improve members’ access to preventive dental services. [Quality, Timeliness, and Access] Both PAHPs’ <i>OED</i> performance measure results demonstrated that members enrolled with the PAHPs received an oral evaluation as frequently as intended by LDH. [Quality, Timeliness, and Access]
Compliance	<ul style="list-style-type: none"> The PAHPs achieved a 100 percent compliance score for Standard XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. [Quality] The PAHPs received high compliance scores for Standard VI—Coordination and Continuity of Care, demonstrating that the PAHPs collaborated with the MCEs to assess members’ needs and coordinate care. [Quality] The PAHPs received high compliance scores for Standard XII—Quality Assessment and Performance Improvement, demonstrating that the PAHPs had comprehensive policies, systematic monitoring, and ongoing program evaluation consistent with federal and contractual standards. [Quality]
NAV	<ul style="list-style-type: none"> Both PAHPs had high levels of member access for the provider types of general dentist, oral surgeon, and orthodontist. [Timeliness and Access]
EDV	<ul style="list-style-type: none"> Both PAHPs had less than 0.1 percent of duplicated dental encounters. [Quality] Both PAHPs had 97 percent or more of their dental providers accurately matched in the provider data. [Quality]

Overall PAHP Strengths	
CAHPS	<ul style="list-style-type: none"> Both PAHPs showed statistical improvements in the following CAHPS measurements: <i>Rating of All Dental Care, Rating of Dental Plan, Access to Dental Care, Dental Plan Information and Services, and Would Recommend Dental Plan.</i> [Quality, Timeliness, and Access]

Table 8-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall PAHP Opportunities for Improvement	
PIP	<ul style="list-style-type: none"> For both PAHPs, no opportunities for improvement were identified. [Quality]
PMV	<ul style="list-style-type: none"> Both PAHPs’ performance measure results fell below the LDH-established goal for the 2025 reporting period, suggesting an opportunity for improvement for members to receive a preventive dental service. [Quality, Timeliness, and Access]
Compliance	<ul style="list-style-type: none"> The PAHPs’ average CR results demonstrated low compliance with Standard V—Adequate Capacity and Availability of Services (36 percent). [Quality and Access] The PAHPs’ average CR results demonstrated low compliance with Standard IX—Subcontractual Relationships and Delegation (40 percent). [Quality] The PAHPs’ average CR results demonstrated low compliance with Standard X—Practice Guidelines (50 percent). [Quality and Access]
NAV	<ul style="list-style-type: none"> Both PAHPs had opportunities to improve member services and provider access for endodontists, periodontists, and prosthodontists within a 75-mile radius. [Timeliness and Access]
EDV	<ul style="list-style-type: none"> Neither PAHP reported performing completeness and accuracy, timeliness, or reconciliation with financial reports checks on their dental encounters. [Quality and Timeliness]
CAHPS	<ul style="list-style-type: none"> For the adult and child CAHPS populations for both PAHPs, no substantial opportunities were identified. [Quality, Timeliness, and Access]

Table 8-3—Recommendations

Overall PAHP Recommendations		
EQR Activities	Recommendation	Associated Quality Strategy Goals to Target for Improvement
PIP	<ul style="list-style-type: none"> For both PAHPs, no recommendation were identified. [Quality] 	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
PMV	<ul style="list-style-type: none"> HSAG recommends that the PAHPs work with dental service providers to ensure 	Goal 1: Ensure access to care to meet enrollee needs

Overall PAHP Recommendations		
	that Medicaid members have access to preventive services from “infancy and continuing to adolescence and beyond,” as recommended by the American Academy of Pediatric Dentistry. [Quality, Timeliness, and Access]	Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities
Compliance	<ul style="list-style-type: none"> The PAHPs must consult their CR results and develop corrective actions related to <i>Not Met</i> findings. [Quality, Timeliness, and Access] 	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
NAV	<ul style="list-style-type: none"> HSAG recommends that LDH and the PAHPs collaborate to identify barriers to care and what steps may be taken to assist in improving access for members to these specialty dental provider types. [Timeliness and Access] 	Goal 1: Ensure access to care to meet enrollee needs
EDV	<ul style="list-style-type: none"> Both PAHPs should build additional encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of their dental encounter data. [Quality and Timeliness] 	Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
CAHPS	<ul style="list-style-type: none"> HSAG recommends that the PAHPs monitor the CAHPS measures to ensure significant decreases in scores over time do not occur. [Quality, Timeliness, and Access] 	Goal 1: Ensure access to care to meet enrollee needs Goal 3: Facilitate patient-centered, whole-person care

9. Follow-Up on Prior Year's Recommendations

Table 9-1 through Table 9-10 contain a summary of the follow-up actions that the PAHPs completed in response to the EQRO's SFY 2023 recommendations. Furthermore, HSAG assessed the PAHPs' approach to addressing the recommendations. Please note that the responses in this section were provided by the PAHPs and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

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

High indicates *all* of the following:

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

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



Medium indicates one or more of the following:

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

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



Low indicates one or more the following:

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

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



DQ

Table 9-1—Follow-Up on Prior Year’s Recommendations for PIPs


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


Table 9-2—Follow-Up on Prior Year’s Recommendations for Performance Measures

Recommendation
The PAHPs should conduct a root cause analysis or focused study to determine why some members were not always receiving at least one preventive dental service or dental visit during the year. Upon identification of a


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


Table 9-3—Follow-Up on Prior Year’s Recommendations for Compliance With Medicaid Managed Care Regulations

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

Table 9-4—Follow-Up on Prior Year’s Recommendations for Network Adequacy

<p>Recommendation</p>
<p>To improve access to care, the PAHPs should conduct an in-depth review of provider types for which GeoAccess standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.</p>
<p>Response</p>
<p>Describe initiatives implemented based on recommendations: MCNA implemented complementary reporting tools that provide visibility into historical demographic changes not available within the DentalTrac user interface.</p>
<p>Identify any noted performance improvement as a result of initiatives implemented (if applicable): MCNA demonstrated the ability to query historical data layers and audit logs via IBM Cognos and to monitor discrepancies between 834 enrollment data and demographic updates obtained from other sources, supporting its ongoing monitoring and reporting</p>
<p>Identify any barriers to implementing initiatives: DentalTrac does not offer operational support for the demographic changes so they implemented other supplemental monitoring supports.</p>


<p>Identify strategy for continued improvement or overcoming identified barriers: None identified.</p>
<p>HSAG Assessment</p> 

Table 9-5—Follow-Up on Prior Year’s Recommendations for EDV

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

Table 9-6—Follow-Up on Prior Year’s Recommendations for CAHPS

<p>Recommendation</p>
<p>CAHPS was a new activity; therefore, HSAG did not have prior year recommendations.</p>

MCNA

Table 9-7—Follow-Up on Prior Year’s Recommendations for PIPs

<p>Recommendation</p>
<p>None identified.</p>

Table 9-8—Follow-Up on Prior Year’s Recommendations for Performance Measures

<p>Recommendation</p>
<p>HSAG recommended that the PAHPs conduct a root cause analysis or focused study to determine why some members were not always receiving at least one preventive dental service or dental visit during the year. Upon identification of a root cause, the PAHPs should implement appropriate interventions to continue to improve performance related to the CMS-416 12b and Annual Dental Visit performance measures.</p>
<p>Response</p>
<p>Describe initiatives implemented based on recommendations: MCNA engaged our Member Advocate team and outreach specialists to collect member-specific insights into why annual dental visits and preventive services were not consistently utilized. These findings were complemented by feedback from our Dental Advisory Committee, which provided valuable perspective on appointment adherence trends and systemic challenges. Analysis revealed multiple barriers, including Social Determinants of Health, limited oral health literacy, transportation difficulties, language and cultural barriers, and scheduling conflicts due to work or school obligations. To address these issues, MCNA deployed enhanced business intelligence tools to identify high-risk populations and geographic areas, enabling targeted interventions. We also expanded partnerships with Community-Based Organizations to assist members with transportation, education, and resource navigation. Additionally, MCNA strengthened provider engagement</p>


strategies to improve appointment availability and reduce missed visits. These initiatives build upon prior successful efforts and remain central to our continuous quality improvement framework.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): MCNA's FFY 2025 preventive services rate increased by more than three percentage points compared to the previous year. In addition, MCNA's CY 2025 oral evaluation rate is on track to exceed last year's results.
Identify any barriers to implementing initiatives: There are no barriers to implementing interventions.
Identify strategy for continued improvement or overcoming identified barriers: MCNA will continue to analyze parish-level and neighborhood-specific data to evaluate the effectiveness of interventions aimed at reducing Social Determinants of Health barriers. In addition to monitoring these geographic trends, we will refine targeted strategies to improve both annual dental visit rates and preventive service utilization. Our 2026 Performance Improvement Project (PIP) incorporates rapid-cycle analysis to quickly identify gaps, measure the impact of interventions, and adjust approaches in real time. Furthermore, MCNA will integrate member feedback and provider input into these evaluations to ensure interventions remain relevant and effective. All findings and progress will be documented through Quality Improvement Committee minutes and shared with LDH to maintain transparency and accountability.
HSAG Assessment


Table 9-9—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 9-10—Follow-Up on Prior Year's Recommendations for Network Adequacy

Recommendation
HSAG recommended that LDH review its reporting template against the contractual language to align with and more accurately reflect the LDH-desired reporting information captured by the plans and to ensure consistent reporting.
Response
Describe initiatives implemented based on recommendations: MCNA collaborated with LDH to review and align our network adequacy reporting template with contractual requirements. We implemented internal audits of the reporting process and updated workflows to ensure that all LDH-specified data elements are captured accurately. Our Provider Relations and Network Development teams enhanced grassroots recruitment strategies, leveraging resources such as the Louisiana State Board of Dentistry, NPES NPI Registry, and LA Dental Association to maintain compliance and improve network adequacy reporting. Further: Contract to Template Crosswalk. We completed a line by line mapping of the LDH dental Network Adequacy reporting template (Report 220) to applicable DBPM contractual clauses and Special Contract Exhibits. This includes explicit linkage to items in

Attachment B – Statement of Work (e.g., access, timeliness, and reporting obligations) so every reported data element traces to a contract source.

Versioned, documented template updates.

MCNA’s current 220 template includes a “Network Standards” tab, explicit revision history, and the semi annual due date convention (July 31 and January 31). This creates an auditable path from standard → calculation → output and reduces ambiguity during EQR validation.

Normalized provider coding to LDH standards.

To improve definitional consistency (e.g., specialty/taxonomy, NPI handling, and T MSIS aligned fields), we harmonized our provider file and reporting logic with LDH’s MCE Provider Registry/Directory specifications so that plan submissions use the same provider type/specialty/sub specialty codes LDH and the FI expect.

Strengthened methods documentation for EQR review.

We expanded our ISCAT/NAV methods package (data lineage, indicator formulas, and control points) to show how each indicator in Report 220 is sourced, transformed, and quality checked—facilitating HSAG’s NAV procedures and eliminating interpretive gaps during validation.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

The network continues to grow due to targeted recruitment efforts and established provider relationships. These initiatives have improved reporting accuracy and reduced discrepancies between LDH expectations and submitted data.

Identify any barriers to implementing initiatives:

Persistent provider shortages in rural and specialty areas remain a challenge. Specialists rarely open new practices in shortage areas, and those available often do not contract for government programs.

Identify strategy for continued improvement or overcoming identified barriers:

MCNA will continue proactive outreach to specialists, update provider listings frequently, and leverage advisory committees to identify providers willing to serve shortage areas. We also monitor LDH updates to ensure ongoing alignment with contractual language.

HSAG Assessment



Recommendation

HSAG recommended that the PAHPs explore their system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than the information provided through the 834 file.

Response

Describe initiatives implemented based on recommendations:

MCNA enhanced its Health Information System workflows to incorporate demographic updates from multiple touchpoints, including provider encounters and member services interactions. We integrated these updates into our MIS data flow and encounter data processes to ensure LDH-required fields are consistently refreshed.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Our system improvements have increased the timeliness and accuracy of demographic data, reducing reliance on static 834 file updates and improving member-level reporting integrity.

Identify any barriers to implementing initiatives:

Challenges include variability in data received from external sources and ensuring real-time updates across multiple systems without introducing errors.

Identify strategy for continued improvement or overcoming identified barriers:

MCNA will continue refining data integration protocols, expand provider training on demographic capture, and explore automation tools to synchronize updates across platforms.

HSAG Assessment



Table 9-11—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 9-12—Follow-Up on Prior Year’s Recommendations for CAHPS

Recommendation

CAHPS was a new activity; therefore, HSAG did not have prior year recommendations.

Appendix A. PAHP Response to the Health Disparities Questionnaire

PAHP Verbatim Response to HSAG's Health Disparities Questionnaire¹¹

For the annual EQR technical report, HSAG requested information from each PAHP regarding its activities related to identifying and/or addressing gaps in health outcomes and/or healthcare among its Medicaid population according to at-risk characteristics such as race, ethnicity, gender, and geography. The PAHPs were asked to respond to the following questions for the period of July 1, 2024, through June 30, 2025:

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

DQ Verbatim Response:

Between July 1, 2024, and June 30, 2025, DentaQuest implemented several initiatives aimed at reducing oral health disparities among Louisiana's Medicaid population. Oral health literacy remains a significant barrier to care, contributing to low utilization of dental services and poorer overall health outcomes. To address this, DentaQuest implemented a range of supports, member education, community outreach, and incentive programs. This improves the members' oral health knowledge and arms them with the skills needed to maintain and manage their oral health effectively.

DentaQuest's efforts being with all members receiving a welcome call and Health Risk Assessment (HRA) within 30 days of enrollment. During the welcome call, members are educated on their dental benefits, the importance of routine preventive care, and how to access support services. The secondary component of the call, the Health Risk Assessment, consists of targeted questions designed to identify members who may be at risk due to poor oral health, dental pain, chronic medical conditions, or social factors such as transportation, housing, food, or utility needs. When a member is identified as at-risk, a Care Coordinator conducts a more comprehensive assessment to determine the appropriate level of support. Members requiring short-term assistance to overcome barriers and improve access to care are enrolled in Care Coordination, while those needing long-term, ongoing support are placed in Case Management. The Case Management program provides sustained engagement to promote member self-management, adherence to treatment, and improved oral health outcomes. This structured, proactive approach ensures that at-risk members receive individualized support addressing both clinical and social determinants of health, ultimately advancing oral health equity across Louisiana's Medicaid population.

¹¹ Please note that the narrative within the PAHP Response to the Health Disparities Questionnaire section was provided by the PAHP and has not been altered by HSAG except for formatting.

Research shows that dental caries is the most common chronic disease among children in the United States. Evidence-based clinical recommendations confirm that dental sealants are highly effective in reducing the incidence of carious lesions in permanent molars. To help combat dental caries and align with national sealant utilization benchmarks, DentaQuest implemented a program to promote sealant utilization with the Healthy Behaviors Program. Through the Healthy Behaviors Program, children receive an oral health kit when they have their adult molars sealed—reinforcing preventive oral hygiene behaviors and encouraging continued engagement in care.

Medicaid-enrolled children are also at higher risk for developing Early Childhood Caries (ECC)—a severe form of tooth decay affecting the primary teeth of infants, toddlers, and preschoolers. ECC can progress rapidly, causing pain, infection, and impaired quality of life. To address this, DentaQuest promotes prevention and early detection through parent and caregiver education. Parents and caregivers of enrollees aged 0–2 years receive educational messaging at birth, as well as at the child’s first and second birthdays, emphasizing the importance of early dental visits, proper oral hygiene, and diet in preventing ECC. Educational materials are supported by access to resources and provider contact information to help families establish a dental home early in the child’s life.

Oral health during pregnancy is a critical component of maternal and infant well-being. Poor oral health has been linked to adverse outcomes such as preterm birth, low birth weight, and early childhood caries. Despite this, many women do not engage in dental care during pregnancy. Recognizing the importance of this issue, the Centers for Medicare & Medicaid Services (CMS) has placed increasing emphasis on improving access to dental care for pregnant and postpartum Medicaid enrollees. To address this disparity, DentaQuest conducts targeted outreach and education to pregnant members. Educational materials highlight the safety and importance of preventive and routine dental care during pregnancy. Pregnant enrollees experiencing multiple barriers to care are offered individualized care coordination, providing specialized education, and support in addressing social determinants of health that may prevent access to care. Through these combined efforts, DentaQuest promotes oral health literacy, increases utilization of dental services during pregnancy, and contributes to improved maternal and infant health outcomes.

DentaQuest remains committed to advancing oral health equity and will continue to assess the membership for opportunities to improve oral health literacy and encourage routine dental care. Providing members with education, tools and knowledge to understand the importance of prevention will help them prioritize their oral health.

MCNA Verbatim Response:

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

MCNA Dental also works with these community partners to assist uninsured people with locating resources from medical to dental to financial.

Corporate level activities to date include:

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

At the local level, MCNA Dental has:

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

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

- For the time period of July 1, 2024 through June 30, 2025, MCNA deployed 33,121 preventive text messages, (one per household) advising the parent/guardian to schedule an appointment for preventive dental care.
 - Of the 33,121 members who received a text, 12,788 (39%) members visited their primary care dentist and 11,671 (91%) of those members received a preventive service within 60 days post receipt of a text message.

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



Lastly, the Practice Site Performance Summary (PSPS) reports were distributed to 1,442 providers. This tool is designed to assist providers in understanding how their clinical and operational performance compares with that of their peers. A preventive services section of the report includes the percent of assigned children receiving a preventive visit in accordance with the American Association of Pediatric Dentistry's Periodicity Schedule. Each provider receives a detailed quarterly report that outlines individual provider performance with respect to claims, prior authorizations, and preventive services in comparison to goals and peer groupings.