LOUISIANA DEPARTMENT OF HEALTH

State Fiscal Year July 1, 2022–June 30, 2023

External Quality Review Technical Report

for

Humana Healthy Horizons

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgments and Copyrights

1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral health care, including Humana Healthy Horizons, which started on January 1, 2023; and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 14, 2023.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 14, 2023.

1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2023 (July 1, 2022–June 30, 2023) are displayed in Table 1-1.

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 (new plan as of 01/01/2023)	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA
Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS EQR Protocols released in February 2023.[1-3] For the SFY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 14, 2023.

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)	This activity assesses the extent to which an MCE has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*	✓	✓	✓
Consumer Surveys: CAHPS-A and CAHPS-C	This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Behavioral Health Member Satisfaction Survey	This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
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	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
	services have on members receiving those services.				
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	✓		

**Protocol 4. Validation of Network Adequacy* was released in February 2023; therefore, full implementation will occur with the 2024 NAV activities.

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2023. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

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

Definitions

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

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

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

Methodologies

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

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO, as well as the program overall. To produce Healthy Louisiana's MCO aggregate SFY 2023 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs:

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

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

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

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

Louisiana's Medicaid Managed Care Quality Strategy

In accordance with 42 CFR §438.340, LDH implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Louisiana Medicaid managed care members under the Louisiana Medicaid managed care program. Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated June 2022 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 Louisiana Medicaid managed care program is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid members.

Goals and Objectives

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

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

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

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

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

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

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

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

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

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

LDH considers the quality strategy to be its roadmap for the future. Overall, the quality strategy represents an effective tool for measuring and improving the quality of Louisiana's Medicaid managed care services. The quality strategy promotes identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Louisiana Medicaid managed care members. Additionally, LDH's initiatives tie to the quality strategy aims, goals, and objectives. The quality strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value- and quality-based, data-driven, and equitable.

LDH conducts oversight of the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. The MCE should be committed to QI and its overall approach, and specific strategies will be used to advance the quality strategy and incentive-based quality measures.

Recommendations

HSAG's EQR results and guidance on actions assist LDH in evaluating the MCEs' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist LDH and the MCEs in achieving and exceeding goals. In addition to providing each MCE with specific guidance, HSAG offers LDH the following recommendations, which should positively impact the quality, timeliness, and accessibility of services provided to Medicaid members:

- HSAG recommends LDH consider a change in metric benchmarks so the MCEs can strive toward a consistent performance level. HSAG recommends LDH remove the target objectives and improvement objectives and establish benchmarks for all MCEs that align with nationally recognized quality measures (e.g., NCQA Quality Compass, CMS Adult and Child Core Sets) or the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.

[1-4] Health Services Advisory Group, Inc. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Dec 12, 2023.

- HSAG recommends LDH consider using the measurement year (MY) 2023 reported rates in the 2024 quality strategy evaluation, which could include MY 2021 through MY 2023 results in order to include the most current data for evaluation.
- HSAG recommends LDH remove the duplicate objective, promote healthy development and wellness in children and adolescents.
- HSAG recommends LDH consider adding the objectives, improve overall health and promote reproductive health objectives, to the quality strategy.
- HSAG recommends LDH continue to collaborate with the MCOs to support adequate QI capacity, skills, and resources to support current and future PIPs. HSAG recommends LDH continue to meet regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could consider incorporating a similar mechanism for the PAHPs to collaborate on current and future PIPs. HSAG also recommends LDH consider hosting a forum in which the MCEs could discuss programwide solutions to overcome barriers. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.
- HSAG recommends LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.
- HSAG recommends the MCEs consider whether there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends the MCEs target QI interventions to reduce the identified disparities.
- HSAG recommends LDH consider working with the MCEs to share performance measure best practices and identify interdependencies across measures.
- HSAG recommends LDH consider a contract statement for all MCEs that the MCE's quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.
- HSAG recommends LDH consider removing aim statements from the quality strategy. CMS defines "quality strategy goals" as SMART (specific, measurable, attainable, relevant, and time-bound), high-level managed care performance aims that provide direction for the State. CMS defines quality strategy (SMART) objectives as measurable steps toward meeting the State's goals that typically include quality measures.

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for Humana Healthy Horizons (HUM) conducted with Louisiana Medicaid managed care throughout SFY 2023.

Validation of Performance Improvement Projects

With the start of HSAG's EQRO contract with LDH in March 2023, HSAG initiated PIP validation training and technical assistance activities to assist LDH, HUM, and other MCOs in transitioning to HSAG's PIP validation process and methodology. HUM began operations to serve Healthy Louisiana enrollees in 2023 and actively worked on PIPs throughout the year. HSAG also initiated validation activities for HUM's PIPs in 2023. LDH required HUM to conduct PIPs on the following five state-mandated topics during SFY 2023:

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

At the time this report was drafted, HSAG's first validation cycle of HUM's PIPs was in progress and is scheduled to be completed in SFY 2024; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations will be reported in next year's annual EQR technical report.

Validation of Performance Measures

For SFY 2023 reporting, HUM did not submit HEDIS MY 2022 data, a final audit report (FAR), or calendar year (CY) 2022 performance measure validation (PMV) data since HUM was a new MCO to Louisiana Medicaid as of January 1, 2023. Therefore, HSAG's final validation findings, including an assessment of performance measure results, interventions, strengths, opportunities, and recommendations, are not reflected in the SFY 2023 EQR technical report. HEDIS results will be presented for HUM in the SFY 2024 EQR technical report, as HUM's HEDIS MY 2023 data and FAR will be made available to HSAG.

Assessment of Compliance With Medicaid Managed Care Regulations

HUM was a new MCO to Louisiana Medicaid as of January 1, 2023; therefore, HUM was not included in the CR since the review period covered CY 2021 and CY 2022.

Validation of Network Adequacy

HSAG's provider directory validation (PDV) indicated that, overall, the provider information maintained and provided by HUM was poor, which impacted access to care due to the inability of members to find a provider that delivered the requested services. Table 1-3 provides a summary of the findings from the study.

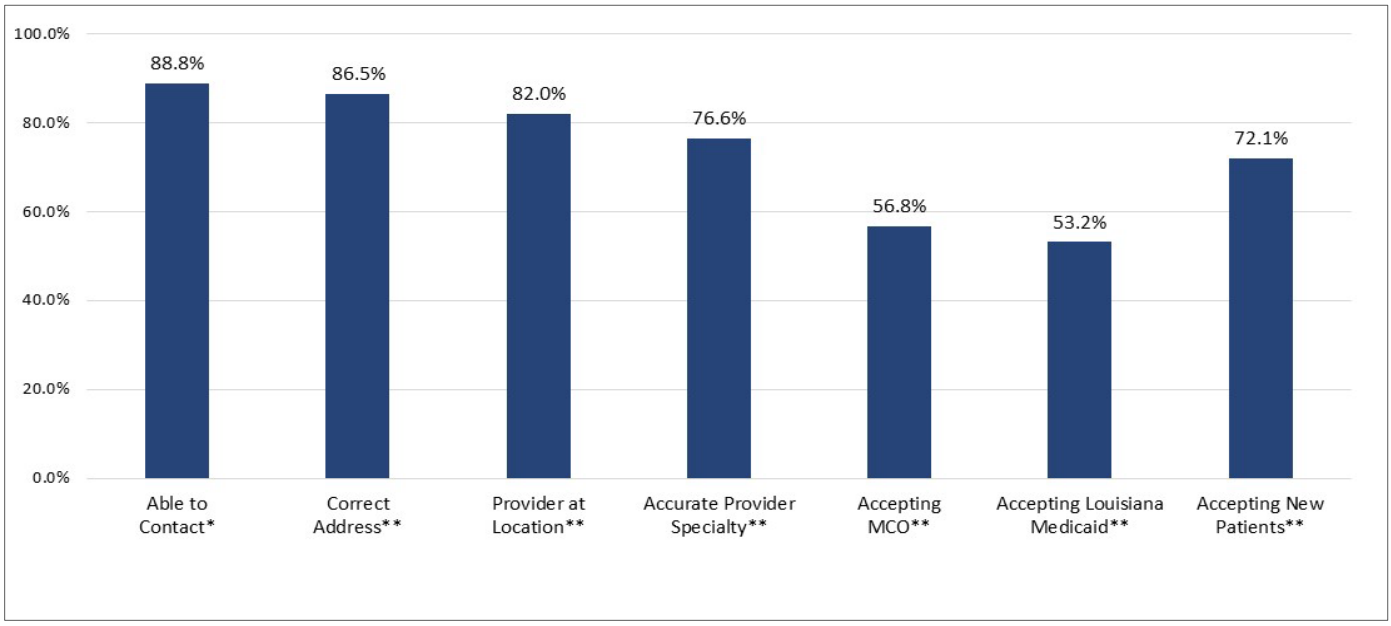
Table 1-3—Summary of Findings

Concerns	Findings
Acceptance of Louisiana Medicaid was inaccurate.	Overall, 53.2 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was inaccurate.	Overall, 56.8 percent of providers accepted the requested MCO.
Provider's specialty in the provider directory was incorrect.	Overall, 76.6 percent of providers confirmed the specialty listed in the online directory was accurate.
Overall acceptance of new patients was low.	Overall, 72.1 percent of providers accepted new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews.
Affiliation with the sampled provider was low.	Overall, 82.0 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 86.5 percent of respondents reported that HUM's provider directory reflected the correct address.

While the overall PDV response rate was relatively high at 88.8 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of new patient acceptance, HUM acceptance, and Louisiana Medicaid acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate below 87.0 percent.

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

Figure 1-1—Summary Results for All HUM Providers



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

HUM's weighted PDV compliance scores by specialty type ranged from 28.0 percent (internal medicine/family medicine) to 58.7 percent (pediatrics).

Quarter 2 through Quarter 4 PDV and provider access survey results were not final at the time of reporting. Final results from these activities will be included in the SFY 2024 EQR technical report.

For geographic access (GeoAccess), HUM reported the percentage of members having access within required distance standards for 19 behavioral health provider types for Quarter 3 (January 1, 2023–March 31, 2023) and Quarter 4 (April 1, 2023–June 30, 2023). Data were reported for a total of 34 behavioral health GeoAccess standards (15 of the behavioral health provider types were reported separately for the urban and rural populations). For the entire SFY 2023, HUM did not meet any GeoAccess standards.

Consumer Surveys: CAHPS-A and CAHPS-C

HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, HUM's members were not eligible to be surveyed, and results for HUM are not included in the SFY 2023 EQR technical report. Results for HUM will be included in the SFY 2024 EQR technical report.

Behavioral Health Member Satisfaction Survey

HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, HUM's members were not eligible to be surveyed, and results for HUM are not included in the SFY 2023 EQR technical report. Results for HUM will be included in the SFY 2024 EQR technical report.

Case Management Performance Evaluation

During SFY 2023, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG will conduct the focus study in SFY 2024. Results, including conclusions, strengths, and opportunities for improvement, will be reported in the SFY 2024 EQR technical report.

Quality Rating System

Figure 1-2 displays the 2023 Health Plan Report Card, which presents the 2023 rating results for each MCO. HUM was not included in the analysis as the MCO did not start providing coverage until MY 2023. HUM will be included in future health plan report cards.

Figure 1-2—2023 Health Plan Report Card

Issued 09/2023

Healthy Louisiana

2023 HEALTH PLAN REPORT CARD

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

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

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

Continued on next page...

Figure 1-2—2023 Health Plan Report Card (cont.)

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

This report card is reflective of data collected between January 2022 and December 2022.

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

The categories and measures included in this report card are based on the 2023 National Committee for Quality Assurance (NCQA) Health Plan Ratings and LDH required measures lists. When feasible, categories and measures were kept consistent with the prior year's health plan report card, but some measures and categories were removed due to data availability. Any analysis, interpretation, and conclusions based on the data is solely that of the author. Anyone desiring to use or reproduce the materials must obtain approval from LDH.

2. Validation of Performance Improvement Projects

Results

SFY 2023 was the first year that HSAG was contracted as the EQRO for LDH. HSAG's EQRO contract with LDH was initiated in March 2023, and HSAG initiated PIP validation transition activities, training, and technical assistance activities the same month. During SFY 2023, HSAG worked with LDH to transition the MCOs to HSAG's PIP validation process and methodology. HUM actively worked on PIPs throughout SFY 2023, and HSAG initiated validation activities for HUM's PIPs. At the time this report was drafted, HSAG's first validation cycle of the HUM's PIPs was in progress; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations will be reported in next year's annual EQR technical report.

LDH required the MCOs, including HUM, to carry out PIPs to address five state-mandated topics during SFY 2023. Table 2-1 summarizes the PIP topics carried out by HUM in SFY 2023.

Table 2-1—SFY 2023 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Behavioral Health Transitions in Care	• 6 years and older • 13 years and older
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• 5–11 years • 12–15 years • 16 years and older
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• 6 months–18 months • 19 months–2 years • 3–5 years
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• 21–64 years
Screening for HIV Infection	• 13 years and older • 15–65 years

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

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

Table 2-2—SFY 2023 MCO PIP Activities

PIP Activities and Milestones	Dates
HSAG provided training to LDH and the MCOs on HSAG's PIP validation process and templates	March–April 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	March 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	April 2023
The MCOs submitted Quarter 1 PIP updates	April 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	May 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	June 2023
The MCOs submitted PIP proposals to HSAG for initial review and feedback	June 2023

In SFY 2024, HUM will submit draft PIP reports for initial validation in January 2024 and the final PIP reports for final validation in March 2024. HSAG will complete the first annual validation cycle in April 2024.

Validation Results and Confidence Ratings

Table 2-3 summarizes HUM's PIP validation results and confidence ratings. The initial validation cycle for HUM's PIPs was in progress at the time this report was drafted; therefore, final validation ratings will be reported in next year's annual EQR technical report.

Table 2-3—PIP Validation Results and Confidence Ratings

PIP Topic	Validation Rating 1: PIP Demonstrated Adherence to Acceptable Methodology	Validation Rating 2: PIP Demonstrated Significant Improvement
Behavioral Health Transitions in Care	To be reported in SFY 2024	To be reported in SFY 2025
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	To be reported in SFY 2024	To be reported in SFY 2025
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	To be reported in SFY 2024	To be reported in SFY 2025
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	To be reported in SFY 2024	To be reported in SFY 2025
Screening for HIV Infection	To be reported in SFY 2024	To be reported in SFY 2025

Performance Indicator Results

HUM will report final CY 2023 indicator results in January through March 2024. HSAG will validate the performance indicator results in SFY 2024, and the final performance indicator results for each PIP topic will be included in next year's annual EQR technical report. Table 2-4 summarizes the measurement period that is being completed in CY 2023 and which results will be reported in SFY 2024.

Table 2-4—Measurement Periods in CY 2023 by PIP Topic

PIP Topic	Measurement Period in CY 2023
Behavioral Health Transitions in Care	Baseline
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	Baseline
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	Baseline
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	Baseline
Screening for HIV Infection	Baseline

Interventions

HUM will report final 2023 QI activities and interventions in January through March 2024. Table 2-5 includes barriers and interventions HUM initially reported early in the validation cycle initiated at the end of SFY 2023. HUM will report updated QI activities and interventions in SFY 2024, and HSAG will complete the assessment of HUM's QI activities and interventions when the validation cycle is completed in SFY 2024. An updated summary of HUM's interventions for each PIP topic will be included in next year's annual EQR technical report.

Table 2-5—Barriers and Interventions Reported by HUM for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions in Care	• CM team is only alerted on members that have a certain risk level • Lack of means to track scheduled visits	• Enhance timely hospital-to-MCO notification of hospital and emergency department (ED) admissions, discharges, and transfers • Link enrollees to follow-up care with behavioral health providers prior to discharge from hospital or ED

PIP Topic	Barriers	Interventions
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Challenges with reaching a large volume of eligible members via CM outreach alone	• Offering the COVID-19 vaccination at community events • Distribution of educational materials at community events • COVID-19 vaccination outreach to enrollees engaged in CM
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of enrollee knowledge on fluoride varnish education and access to screening	• Distribution of educational materials at community events • Offering fluoride varnish application at community events
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of provider awareness of Centers for Disease Control and Prevention screening guidelines and recommendations	• Distribution of educational materials at community events • Text message reminder campaign for enrollees to schedule preventive services and screenings
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Community-based distribution of educational materials to promote HIV screening awareness • Offering HIV screenings at community events

MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG will report statewide strengths, opportunities for improvement, and recommendations for HUM's PIPs in next year's annual EQR technical report, when HSAG has completed the first annual validation cycle for HUM's PIPs in SFY 2024

Methodology

Objectives

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

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

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

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

Technical Methods of Data Collection

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

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

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 15, 2023.

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

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

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   a. *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.

b. *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.
c. *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*.
d. *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)

a. *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
b. *Moderate Confidence*: One of the three scenarios below occurred:
   i. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
   ii. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   iii. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
c. *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.
d. *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 weaknesses in each domain of quality, timeliness, and accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across the MCOs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

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

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

addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-6.

Table 2-6—Assignment of PIPs to the Quality, Timeliness, and Access Domains

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

Results

Information Systems Standards Review

An Information Systems Capabilities Assessment (ISCA) was performed as part of HUM's contract readiness review by Mercer, which was issued on November 7, 2022. The ISCA included a comprehensive review of HUM's information systems (IS) and operational policies and processes to support the Healthy Louisiana contract. Mercer supplemented the CMS EQR Protocols, October 2019, Appendix A—ISCA[3-1] with state-specific regulations and contract requirements to inform the evaluation of HUM's systems readiness. The readiness review covered the foundational aspects of HUM's systems to better understand the infrastructure to support the Healthy Louisiana contract, with in-depth functional area interviews and limited claims testing to validate HUM's understanding and preparations to support these requirements.

Mercer's readiness review consisted of a comprehensive overview of HUM's IS, programming support, claims management, member portal, provider portal, provider data, and encounter data. Discussions on State and performance measure reporting, system demonstrations, and review of cases in HUM's test environment also occurred as part of the readiness review.

Outlined below is a summary of the requested follow-up items from HUM for the ISCA:

- Business Continuity Disaster Recovery Plan: Provide written documentation specific to the business continuity plan for Louisiana.
- Programming processes: Provide the information technology testing and defect standards documentation that is specific to the Louisiana Medicaid managed care program.
- Access to data: Provide the list of data tables and fields proposed for the LDH data mart for review and approval.
- Claims staffing: Provide weekly staffing update to LDH as outlined in the Administration and Organization follow-up table concerning staffing of claims and encounters areas.
- Claims policy: Provide finalized policy and procedure document for claims processing.
- Claim edits: Provide list of claim edits performed on the eHub platform.
- Provider appeals: Provide finalized policy and procedures for the provider appeals process, including the arbitration process.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 26, 2024.

- Provider data: Provide regular updates on the number of outstanding providers to be loaded, as well as a target timeline for when Humana will initiate the initial primary care physician assignment routine.
- Encounters: Encounters testing process completed.

HUM was a new MCO to Louisiana Medicaid as of January 1, 2023; therefore, HUM did not have a MY 2022 FAR to submit for SFY 2023 reporting. As such, HSAG's findings related to each HEDIS IS standard is not reflected in the SFY 2023 EQR technical report.

Performance Measures

As a new MCO to Louisiana Medicaid as of January 1, 2023, HUM did not have MY 2022 data to submit for SFY 2023 reporting. As such, HSAG did not conduct a validation of performance measures for HUM for SFY 2023. Therefore, final validation findings are not reflected in the SFY 2023 EQR technical report. However, results will be presented for HUM in the SFY 2024 EQR technical report.

MCO Strengths, Opportunities for Improvement, and Recommendations

As a result of HUM's readiness review, the following opportunities for improvement were identified by Mercer:

- HUM was using the same process for encounters as is used in other states with which it is contracted and felt that getting encounters up and running would not be a difficult task. However, Mercer expressed concerns with the lack of Louisiana-dedicated staff that had the opportunity to gain a complete and full understanding of LDH's encounter submission requirements and systems capabilities and limitations. **[Quality and Timeliness]**
- HUM did not have a Louisiana Medicaid-specific business continuity plan available for Mercer's review at the time of the readiness review. **[Quality]**

As a result of HUM's readiness review, the following recommendations were identified by Mercer:

- Mercer recommended that HUM ensure it assigns a dedicated encounters subject matter expert to learn about the nuances of LDH's encounter submission requirements to minimize encounter rejections and the need to correct encounters after go-live. **[Quality and Timeliness]**
- Mercer recommended that HUM ensure there is a business continuity plan specific to the Louisiana Medicaid line of business. **[Quality]**

HSAG's identified strengths, opportunities for improvement, and recommendations for HUM will be included in the SFY 2024 EQR technical report, as it will be the first year that HUM's data and FAR will be made available.

Methodology

Objectives

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

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

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

Technical Methods of Data Collection

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

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

HEDIS Measure Validation

The MCOs that report HEDIS measures to NCQA must undergo an audit of their data conducted by an NCQA HEDIS Compliance Audit LO. For these HEDIS measures, HSAG reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the measure rates and any problems that the MCOs experienced in the HEDIS process. Included in the FAR are the measures deemed *Not Reportable* due to biases in the calculation process.

[3-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

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

Non-HEDIS Measure Validation

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

In accordance with the MY 2022 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. For each HEDIS measure, the MCO was evaluated on how its rate compared to the NCQA Quality Compass MY 2022 national 50th percentile Medicaid HMO benchmark.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the 2022 performance levels based on comparison to the NCQA national 50th percentile benchmark percentile to

identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCO's Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-1. The measures marked *NA* are related to utilization of services.

Table 3-1—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Childhood Immunization Status—DTaP, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Pneumococcal Conjugate, Hepatitis A*, *Rotavirus*, *Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*	✓		✓
Immunization Status for Adolescents—Meningococcal, *Tdap/Td*, *HPV*, *Combination 1*, and *Combination 2*	✓		
Colorectal Cancer Screening	✓		
Cervical Cancer Screening	✓		
Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%) and *HbA1c Control (<8.0%)*	✓		
Controlling High Blood Pressure	✓		
HIV Viral Load Suppression	✓		
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)	✓		
Child and Adolescent Well-Care Visits—3–11 Years, *12–17 Years*, *18–21 Years*, and *Total*	✓		✓
Well-Child Visits in the First 30 Months of Life—First 15 Months and *15 Months–30 Months*	✓		✓
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Ambulatory Care—Outpatient Visits/1,000 MM and *Emergency Department Visits/1,000 MM*	NA	NA	NA

Performance Measure	Quality	Timeliness	Access
Plan All-Cause Readmissions—Observed Readmissions, *Expected Readmissions*, and *O/E Ratio*	✓		
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan, 8+9+10)	✓		
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan—General Population, 8+9+10)	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Flu Vaccinations for Adults Ages 18 to 64	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation, *Counseling for Nutrition*, and *Counseling for Physical Activity*	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total and *Statin Adherence 80%—Total*	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Eye Exam for Patients With Diabetes	✓		
Pharmacotherapy for Opioid Use Disorder	✓		
Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD and *Engagement of SUD*	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		

Performance Measure	Quality	Timeliness	Access
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Non-Recommended Cervical Screening in Adolescent Females	✓		
Depression Screening and Follow-Up for Adolescents and Adults	✓		
Self-Reported Overall Health (Adult)—Adult—Very Good and *Adult—Excellent*	✓		
Self-Reported Overall Health (Child General)—Child General—Very Good and *Child General—Excellent*	✓		
Self-Reported Overall Health (Child CCC)—Child CCC—Very Good and *Child CCC—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Adult)—Adult—Very Good and *Adult—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Child General)—Child General—Very Good and *Child General—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Child CCC)—Child CCC—Very Good and *Child CCC—Excellent*	✓		
Use of Imaging Studies for Low Back Pain	✓		

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

In CY 2022, the first year of a new three-year review cycle, LDH's former EQRO conducted a CR covering a review period of CY 2021 and most of the federally required standards. In CY 2023, HSAG conducted a CR for Standard I—Enrollment and Disenrollment (this standard had not been included in the prior year's CR), thereby completing the required evaluation for the administrative and compliance process in a three-year period. However, HUM was a new MCO to Louisiana Medicaid as of January 1, 2023; therefore, HUM was not included in the CR since the review period covered CY 2021 and CY 2022.

Methodology

Standards

Table 4-1 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In addition, HSAG conducted a follow-up review of each MCO's implementation of CAPs from the CY 2021 CRs.

Table 4-1—Summary of CR Standards

Standard	Year One (CY 2021)			Year Two (CY 2022)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment				✓	✓	✓
Standard II—Member Rights and Confidentiality	✓	✓	✓			
Standard III—Member Information	✓	✓	✓			
Standard IV—Emergency and Poststabilization Services	✓	NA				✓
Standard V—Adequate Capacity and Availability of Services	✓	✓	✓			
Standard VI—Coordination and Continuity of Care	✓	✓	✓			
Standard VII—Coverage and Authorization of Services	✓	✓	✓			
Standard VIII—Provider Selection	✓	✓	✓			
Standard IX—Subcontractual Relationships and Delegation	✓		✓		✓	
Standard X—Practice Guidelines	✓	✓	✓			
Standard XI—Health Information Systems	✓	✓	✓			

Standard	Year One (CY 2021)			Year Two (CY 2022)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard XII—Quality Assessment and Performance Improvement	✓	✓	✓			
Standard XIII—Grievance and Appeal Systems	✓	✓	✓			
Standard XIV—Program Integrity	✓	✓	✓			

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table 4-2 describes the standards and associated regulations and requirements reviewed for each standard.

Table 4-2—Summary of CR Standards and Associated Regulations

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

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

Objectives

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

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

Technical Methods of Data Collection

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

Table 4-3—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and LDH contract requirements: • HSAG and LDH collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted CR tools, report templates, and agendas, and sent review dates to LDH for review and approval. • HSAG forwarded the CR tools and agendas to the MCOs. • HSAG scheduled the virtual reviews to facilitate preparation for the reviews.

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

For this protocol activity,	HSAG completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCO pre-virtual review preparation session to describe HSAG's processes and allow the MCOs the opportunity to ask questions about the review process and MCO expectations. • HSAG confirmed a primary MCO contact person for the review and assigned HSAG reviewers to participate. • During the MCO pre-virtual review preparation session, HSAG notified the MCOs of the request for desk review documents. HSAG delivered a desk review form, the CR tool, CAP implementation review tool, and a webinar review agenda via HSAG's Secure Access File Exchange (SAFE) site. The desk review request included instructions for organizing and preparing the documents to be submitted. The MCO provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and CR consisted of the completed desk review form, the CR tool with the MCO's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct MCO Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual review activities. • During the review, HSAG met with groups of the MCO's key staff members to obtain a complete picture of the MCO's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the 2023 LDH-approved CR Report Template to compile the findings and incorporate information from the CR activities. • HSAG analyzed the findings and calculated final scores based on LDH-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to LDH**
	• HSAG populated and submitted the draft reports to LDH and the MCOs for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports.

For this protocol activity,	HSAG completed the following activities:
	• HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the MCOs and LDH.

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the MCOs. Table 4-4 depicts assignment of the standards to the domains of care.

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

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
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	✓	✓	✓

Results

Provider Access Surveys

The provider access survey results were not final at the time of reporting. Provider access survey results will be included in the SFY 2024 EQR technical report. At the time of reporting, HSAG and LDH finalized the first semiannual provider access survey methodology, and HSAG conducted the survey telephone calls.

Provider Directory Accuracy

This section presents the results from the Quarter 1 PDV for all sampled HUM providers by specialty type. Quarter 2 through Quarter 4 PDV results were not final at the time of reporting and will be included in the SFY 2024 EQR technical report.

Table 5-1 illustrates the survey disposition and response rates for HUM by specialty type.

Table 5-1—Survey Dispositions and Response Rates for HUM by Specialty Type

Specialty Type	Sampled Cases	Respondents	Refusals*	Bad Phone Number**	Unable to Reach***	Response Rate
Total	**125**	**111**	**2**	**4**	**8**	**88.8%**
Internal Medicine/Family Medicine	25	24	0	0	1	96.0%
Pediatrics	25	21	0	2	2	84.0%
Obstetrics/Gynecology (OB/GYN)	25	21	2	0	2	84.0%
Specialists (any)	25	24	0	0	1	96.0%
Behavioral Health (any)	25	21	0	2	2	84.0%

* This includes offices that refused to participate, or the representative did not have enough information to answer the survey questions.
** This includes reaching a disconnected number, fax number, nonmedical facility, or billing office that was unable to transfer/provide corrected number.
*** This includes reaching a voicemail, busy signal, continuous ringing, and/or extended hold time after three attempts.

Table 5-2 illustrates the indicator match rates for HUM by specialty type.

Table 5-2—Indicator Match Rates for HUM by Specialty Type

Specialty Type	Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**96**	**86.5%**	**91**	**82.0%**	**85**	**76.6%**	**63**	**56.8%**	**59**	**53.2%**	**80**	**72.1%**
Internal Medicine/Family Medicine	20	83.3%	21	87.5%	19	79.2%	7	29.2%	7	29.2%	18	75.0%
Pediatrics	21	100%	18	85.7%	17	81.0%	14	66.7%	13	61.9%	16	76.2%
OB/GYN	14	66.7%	20	95.2%	18	85.7%	18	85.7%	16	76.2%	19	90.5%
Specialists (any)	21	87.5%	20	83.3%	20	83.3%	14	58.3%	13	54.2%	17	70.8%
Behavioral Health (any)	20	95.2%	12	57.1%	11	52.4%	10	47.6%	10	47.6%	10	47.6%

Table 5-3 presents HUM's PDV weighted compliance scores by specialty type. Please see the network adequacy validation (NAV) methodology for the weighted compliance score calculation criteria.

Table 5-3—PDV Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**125**	**49**	**44.0%**
Internal Medicine/Family Medicine	25	6	28.0%
Pediatrics	25	12	50.7%
OB/GYN	25	12	58.7%
Specialists (any)	25	11	46.7%
Behavioral Health (any)	25	8	36.0%

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

Table 5-4 presents HUM's reasons for noncompliance.

Table 5-4—Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**76**	**60.8%**
Total reasons for noncompliance	**94**	**Not Applicable**
Provider does not participate with MCO or Louisiana Medicaid	35	28.0%
Provider is not at site	15	12.0%
Provider not accepting new patients	11	8.8%
Wrong telephone number	0	0.0%
No response/busy signal/disconnected telephone number (after three calls)	12	9.6%
Representative does not know	0	0.0%
Incorrect address reported	13	10.4%
Address (suite number) needs to be updated	2	1.6%
Wrong specialty reported	6	4.8%

GeoAccess Provider Network Accessibility

HUM's contract with LDH (effective dates January 1, 2023–December 31, 2025) requires HUM to comply with the following GeoAccess standards:

- Travel distance to adult primary care (family/general practice, internal medicine, Federally Qualified Health Center [FQHC], Rural Health Center [RHC], and pediatric primary care (pediatric practices, family/general practice, internal medicine, FQHC, RHC):
  - Urban—10 miles
  - Rural—30 miles
- Travel distance to acute inpatient hospitals
  - Urban—10 miles
  - Rural—30 miles
- Travel distance to ancillary care (laboratory and radiology):
  - Urban—20 miles
  - Rural—30 miles
- Travel distance to ancillary care (pharmacy and hemodialysis):
  - Urban—10 miles
  - Rural—30 miles

- Travel distance to specialty care (OB/GYN and psychiatrists):
  - Urban—15 miles
  - Rural—30 miles
- Travel distance to all other specialty care (except behavioral health care):
  - Urban—60 miles
  - Rural—60 miles
- Travel distance to licensed mental health specialists (advanced practice registered nurse [APRN], psychologist, licensed clinical social worker [LCSW]):
  - Urban—15 miles
  - Rural—30 miles
- Travel distance to pediatric psychiatric residential treatment facilities (PRTFs) (mental health and American Society of Addiction Medicine [ASAM]):
  - Urban—200 miles
  - Rural—200 miles
- Travel distance to ASAM levels of care (LOCs) (both urban and rural):
  - ASAM LOC 1 (adult and pediatric 1):
    - Urban—15 miles
    - Rural—30 miles
  - ASAM LOC 2.1 (adult and pediatric)
    - Urban—15 miles
    - Rural—30 miles
  - ASAM LOC 2 Withdrawal Management (WM) (adult and pediatric)—60 miles
  - ASAM LOC 3.1 (adult)—30 miles
  - ASAM LOC 3.1 (pediatric)—60 miles
  - ASAM LOC 3.2WM (adult and pediatric)—60 miles
  - ASAM LOC 3.3 (adult)—30 miles
  - ASAM LOC 3.5 (adult)—30 miles
  - ASAM LOC 3.5 (pediatric)—60 miles
  - ASAM LOC 3.7 (adult)—60 miles
  - ASAM LOC 3.7WM (adult)—60 miles
- Travel distance to psychiatric inpatient hospital services (free standing, distinct psychiatric unit):
  - Urban—90 miles
  - Rural—90 miles
- Travel distance to behavioral health rehabilitation services (legacy and non-legacy agency):
  - Urban—15 miles
  - Rural—30 miles

Table 5-5 presents the percentage of members HUM reported having access within the required distance standard for the reporting period of July 1, 2022, through June 30, 2023, for the physical health provider types depicted in Attachment F of HUM's contract with LDH.

Table 5-5—GeoAccess Results for HUM—Physical Health

Provider Type	Region	Standard	Reporting Period 07/01/22—12/31/22	Reporting Period 01/01/23—06/30/23
Adult Primary Care	Urban	10 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Pediatric Primary Care	Urban	10 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
FQHCs	Urban	10 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
RHCs	Urban	10 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Acute Inpatient Hospitals	Urban	10 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Ancillary Care—Laboratory	Urban	20 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Ancillary Care—Radiology	Urban	20 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Ancillary Care—Pharmacy	Urban	10 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Ancillary Care—Hemodialysis	Urban	10 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Specialty Care—OB/GYN	Urban	15 miles/100%	NA	Unavailable
	Rural	30 miles/100%	NA	Unavailable
Allergy/Immunology	Urban	60 miles/100%	NA	Unavailable
	Rural	60 miles/100%	NA	Unavailable
Cardiology	Urban or Rural	60 miles/100%	NA	Unavailable

Provider Type	Region	Standard	Reporting Period 07/01/22—12/31/22	Reporting Period 01/01/23—06/30/23
Dermatology	Urban	60 miles/100%	NA	Unavailable
	Rural	60 miles/100%	NA	Unavailable
Endocrinology and Metabolism	Urban	60 miles/100%	NA	Unavailable
	Rural	60 miles/100%	NA	Unavailable
Gastroenterology	Urban or Rural	60 miles/100%	NA	Unavailable
Hematology/Oncology	Urban	60 miles/100%	NA	Unavailable
	Rural	60 miles/100%	NA	Unavailable
Nephrology	Urban or Rural	60 miles/100%	NA	Unavailable
Neurology	Urban or Rural	60 miles/100%	NA	Unavailable
Ophthalmology	Urban or Rural	60 miles/100%	NA	Unavailable
Orthopedics	Urban or Rural	60 miles/100%	NA	Unavailable
Otorhinolaryngology/ Otolaryngology	Urban or Rural	60 miles/100%	NA	Unavailable
Urology	Urban or Rural	60 miles/100%	NA	Unavailable

Meets the required distance standards
Results of 99.0% or higher

NA—Not Applicable; HUM was a new MCO to the Louisiana market as of January 2023.
Unavailable—Time and distance table for physical health providers for the reporting period of 01/01/23–06/30/23 were unavailable to HSAG for the production of this report.

Table 5-6 presents the percentage of members HUM reported having access within the required distance standard for the reporting period of July 1, 2022, through June 30, 2023, for the behavioral health provider types depicted in Attachment F of HUM's contract with LDH.

Table 5-6—GeoAccess Results for HUM—Behavioral Health

Provider Type	Region	Standard	Quarter 1 07/01/22—09/30/22	Quarter 2 10/01/22—12/31/22	Quarter 3 01/01/23—03/31/23	Quarter 4 04/01/23—06/30/23
Specialty Care—Psychiatrists	Urban	15 miles/100%	NA	NA	94.5%	96.2%
	Rural	30 miles/100%	NA	NA	98.0%	98.9%
Behavioral Health Specialists	Urban	15 miles/100%	NA	NA	98.1%	98.7%
	Rural	30 miles/100%	NA	NA	99.7%	99.8%
All Prescribers	Urban	15 miles/100%	NA	NA	98%	98.5%
	Rural	30 miles/100%	NA	NA	99.4%	99.7%
Pediatric PRTF	Urban or Rural	200 miles/100%	NA	NA	99.9%	0%
ASAM LOC 1	Urban	15 miles/100%	NA	NA	51%	70.4%
	Rural	30 miles/100%	NA	NA	3.6%	9.9%
ASAM LOC 2.1	Urban	15 miles/100%	NA	NA	50.0%	69.6%
	Rural	30 miles/100%	NA	NA	3.6%	8.6%
ASAM LOC 2WM	Urban	60 miles/100%	NA	NA	18.9%	37.4%
	Rural	60 miles/100%	NA	NA	0%	0%
ASAM LOC 3.1 Adult	Urban	30 miles/100%	NA	NA	67.1%	43.2%
	Rural	30 miles/100%	NA	NA	5.4%	3.3%
ASAM LOC 3.1 Pediatric/Adolescent	Urban or Rural	60 miles/100%	NA	NA	91.7%	94.8%
ASAM LOC 3.2WM Adult	Urban	60 miles/100%	NA	NA	52.9%	42.1%
	Rural	60 miles/100%	NA	NA	0.7%	0%
ASAM LOC 3.2WM Pediatric/Adolescent	Urban or Rural	60 miles/100%	NA	NA	0.1%	0%
ASAM LOC 3.3 Adult	Urban	30 miles/100%	NA	NA	79.1%	78.6%
	Rural	30 miles/100%	NA	NA	5.7%	3.3%

Provider Type	Region	Standard	Quarter 1 07/01/22—09/30/22	Quarter 2 10/01/22—12/31/22	Quarter 3 01/01/23—03/31/23	Quarter 4 04/01/23—06/30/23
ASAM LOC 3.5 Adult	Urban	30 miles/100%	NA	NA	69.3%	80.6%
	Rural	30 miles/100%	NA	NA	5.8%	31.1%
ASAM LOC 3.7 Adult	Urban	60 miles/100%	NA	NA	62.8%	89.7%
	Rural	60 miles/100%	NA	NA	1.0%	31.6%
ASAM LOC 3.7WM Adult	Urban	60 miles/100%	NA	NA	91.2%	93.8%
	Rural	60 miles/100%	NA	NA	1.0%	77.9%
ASAM LOC 3.5 Pediatric	Urban or Rural	60 miles/100%	NA	NA	95.4%	99.1%
Inpatient Psychiatric	Urban	90 miles/100%	NA	NA	99.9%	99.9%
	Rural	90 miles/100%	NA	NA	99.9%	99.8%
Medication-Assisted Treatment (MAT)	Urban	15 miles/100%	NA	NA	91.6%	92.8%
	Rural	30 miles/100%	NA	NA	73.0%	67.6%
Behavioral Health Rehabilitation	Urban	15 miles/100%	NA	NA	98.8%	99.1%
	Rural	30 miles/100%	NA	NA	99.7%	99.8%

Meets the required distance standards
Results of 99.0% or higher

NR—Not Reported; MCOs were not required to report these ASAM LOCs prior to January 2023.
NA—Not Applicable; HUM was a new MCO to the Louisiana market as of January 2023.

In HUM's Unmet Service Needs Plan, HUM reported significant data issues that caused certain behavioral health provider types to be misrepresented or under-identified in the data, resulting in low compliance scores for certain provider types. In addition, as HUM worked to develop the behavioral health network pursuant to the new contract with LDH, HUM reported several activities designed to improve data and ensure ongoing improvement in access to care and reporting.

HUM reported that the contracting team engaged in continuously auditing provider data files to effectively identify additional providers in the network and classify them correctly. HUM also reported monitoring other LDH-contracted MCO provider directories to identify potential providers to recruit for participation in the network. In addition, HUM reported outreach to providers to inquire about and understand additional opportunities for recruitment and that several providers were in the contracting phase at the time of reporting to LDH.

HUM acknowledged a shortage of psychiatrists in the state and articulated a commitment to continue contracting with every available psychiatrist.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HUM, the following strengths were identified:

- The overall response rate for the PDV was 88.8 percent. A higher response rate correlates to correct provider data (i.e., telephone number accuracy) and improves a member's ability to contact provider locations when seeking care. **[Quality and Access]**.
- HUM had a PDV match rate of 100 percent for the address indicator (i.e., accuracy of HUM's directory reflecting the correct address) for pediatrics and 95.2 percent for behavioral health. Correct address information is essential for members to locate providers when seeking care. **[Quality and Access]**
- HUM had a PDV match rate of 95.2 percent for the provider affiliation indicator for OB/GYN providers. Correct provider information is essential for members to locate providers when seeking care. **[Quality and Access]**
- HUM had a PDV match rate of 90.5 percent for the new patient acceptance indicator for OB/GYN providers. Correct new patient acceptance is crucial to members seeking care as new patients. **[Quality and Access]**
- For Quarter 3 and Quarter 4, HUM achieved GeoAccess results above 99 percent for rural behavioral health specialists, rural behavioral health prescribers, and urban and rural inpatient psychiatric providers. [**Access]**

For HUM, the following opportunities for improvement were identified:

- Acceptance of Louisiana Medicaid had an overall match rate at 53.2 percent across all provider types in the PDV. **[Quality and Access]**
- Acceptance of the MCO had an overall match rate at 56.8 percent across all provider types in the PDV. **[Quality and Access]**
- Overall, 76.6 percent of providers confirmed the specialty listed in the online directory was accurate. **[Quality and Access]**
- Overall, 72.1 percent of providers confirmed they were accepting new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews. **[Quality and Access]**
- Affiliation with the sampled provider was low in the PDV, with 82.0 percent of the locations confirming affiliation with the sampled provider. **[Quality and Access]**
- Overall, 86.5 percent of PDV respondents confirmed HUM's directory reflected the correct address. **[Quality and Access]**
- HUM demonstrated a shortage of MAT providers in rural areas, with GeoAccess results below 75 percent. **[Access]**
- HUM did not meet any GeoAccess standards for any ASAM provider types. **[Access]**

For HUM, the following recommendations were identified:

- LDH should provide HUM with the case-level PDV data files (i.e., flat files) and a defined timeline by which it will address provider data deficiencies identified during the PDV reviews (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). **[Quality and Access]**
- In addition to updating provider directory information, HUM should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent. **[Quality and Access]**
- For provider types that did not meet GeoAccess standards, HUM should contract with additional providers, if available, or continue to implement strategies for expanding the provider network such as enhanced reimbursement or encouraging providers to expand licensing to add additional ASAM LOCs. **[Quality and Access]**
- HUM should conduct an in-depth review of provider types for which GeoAccess standards were not met, with the goal of determining whether failure to meet the standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Analyses should evaluate the extent to which HUM has requested exemptions from LDH for provider types for which providers may not be available or willing to contract. **[Quality and Access]**
- HUM should evaluate whether offering additional telehealth services could increase compliance with GeoAccess standards. **[Quality and Access]**

Methodology

Objectives

The purpose of NAV activities is to evaluate the sufficiency of the provider network as reported by the MCO, ensure the sufficiency of the network to provide adequate access to all services covered under the contract for all members, and provide recommendations to address network deficiencies.

Technical Methods of Data Collection

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

Provider Directory Validation

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

Provider Access Survey

To conduct the NAV analysis, each MCO used the data request document prepared by HSAG to identify providers potentially eligible for survey inclusion, and to submit provider data files used to populate its online provider directory to HSAG. At a minimum, the data elements requested for each provider included: provider name, Medicaid identification (ID), National Provider Identification (NPI) number, provider specialty, physical (practice) address, telephone number, provider taxonomy code, and whether or not the provider accepted new patients.

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

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 20, 2023.

GeoAccess Provider Network Accessibility Assessment

The MCO was required to submit network analysis reports, GeoAccess mapping and tables, network gap analysis reports, and development plans depicting interventions or activities designed to address identified gaps in the networks. The MCO used GeoAccess mapping software to calculate compliance with contractual distance standards for each required provider type. HSAG compared each MCO's GeoAccess compliance reporting to the contractual standards.

Description of Data Obtained

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

1. PDV, to validate the MCOs' online provider directories to ensure members have appropriate access to provider information. HSAG utilized the MCOs' online provider directories to locate and extract provider data elements required to conduct the survey component of the PDV activity.
2. Provider access survey, to determine the accuracy of the managed care network information supplied to Healthy Louisiana members using the MCOs' provider data files and to ensure that Louisiana provider networks are following the established LDH standard for office-hour appointments. HSAG utilized the MCOs' provider data files used to populate their online provider directories to conduct the survey component of the provider access survey activity.
3. HSAG assessed the GeoAccess Provider Network Accessibility reports and tables, and Gap Analysis reports submitted by each MCO to LDH.

How Data Were Aggregated and Analyzed

Provider Directory Validation

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

- Telephone number
- Address
- Office affiliation with the sampled provider
- Accuracy of provider specialty
- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance

HSAG used the following validation responses to assess each indicator:

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

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-7 were used to calculate the weight of each noncompliance survey outcome.

Table 5-7—Noncompliance Reasons and Weighting

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

Table 5-8—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-7. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

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

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent **or** have a weighted compliance score ≥ 50 percent **and** have improved by ≥ 2 percentage points from the previous quarter.

Provider Access Survey

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

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

Using the results of the survey, HSAG calculated a compliance score for each MCO. The criteria in Table 5-9 were used to calculate the weight of each noncompliance survey outcome.

Table 5-9—Noncompliance Reasons and Weighting

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

Table 5-10—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-9. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

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

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent **or** have a weighted compliance score ≥ 50 percent **and** have improved by ≥ 2 percentage points from the previous quarter.

GeoAccess Provider Network Accessibility Assessment

HSAG used a standard reporting table to aggregate the GeoAccess mapping results for each provider type. HSAG determined whether the results for each provider type were compliant or noncompliant with the contract standards. HSAG then reviewed each MCO's reports to determine whether the MCO developed interventions to address network deficiencies.

How Conclusions Were Drawn

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. For example, HSAG determined that GeoAccess mapping not only provides insight into whether the access to specific providers is sufficient, but also that if network gaps exist, the quality of care a member receives may be impacted if care is received by nonqualified providers or not received at all. HSAG used analysis of the network data obtained to draw conclusions about Healthy Louisiana member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-11.

Table 5-11—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
PDV	✓		✓
Provider Access Survey	✓	✓	✓
GeoAccess Provider Network Accessibility Assessment	✓		✓

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

Results

HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, HUM's members were not eligible to be surveyed, and results for HUM are not included in the SFY 2023 EQR technical report. Results for HUM will be included in the SFY 2024 EQR technical report.

Methodology

Objectives

The CAHPS activity assesses members' experiences with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) and mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents). In addition, some MCOs had an option for members to complete the survey in Spanish and Chinese. Adult members and parents/caretakers of child members completed the surveys from February through May 2023, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed members' experiences with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite measures.[6-1] The global ratings reflected patients' overall experiences with

[6-1] For this report, the 2023 Child Medicaid CAHPS results presented are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

their personal doctor, specialist, MCO, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

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

For this report, HSAG included results for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. HSAG used a cross (+) to denote CAHPS scores with fewer than 100 respondents. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to the 2023 NCQA CAHPS adult and general child Medicaid national averages.[6-2]

HSAG compared each measure rate to the 2023 NCQA national average and identified a statistically significant difference by using the confidence interval for each measure rate. Information provided below the figures discusses statistically significant differences between each measure rate's lower and upper confidence intervals and the 2023 NCQA national average.

Description of Data Obtained

The CAHPS survey asks adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. **The MCOs** contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experiences with their MCO during the last six months of the measurement period (i.e., July through December 2022).

The MCOs' CAHPS vendors administered the surveys from February to May 2023. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[6-3] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

[6-2] National data were obtained from NCQA's 2023 Quality Compass.

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

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2023 achievement scores were compared to their corresponding 2022 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2023 achievement scores and the 2022 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2023 than 2022 is noted with a black upward (▲) triangle. An MCO's score that performed statistically significantly lower in 2023 than 2022 is noted with a black downward (▼) triangle. An MCO that did not perform statistically significantly higher or lower between years is not denoted with a triangle.

Additionally, HSAG compared MCO scores to the NCQA national averages to determine if there were any statistically significant differences. An MCO that performed statistically significantly higher than the 2023 NCQA national average was denoted with a green upward (↑) arrow.[6-4] Conversely, an MCO that performed statistically significantly lower than the 2023 NCQA national average was denoted with a red downward (↓) arrow. An MCO that did not perform statistically significantly higher or lower than the 2023 NCQA national average was not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2023 survey results to the 2023 NCQA national averages to determine if there were any statistically significant differences. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains. This assignment to the domains is depicted in Table 6-1.

Table 6-1—Assignment of CAHPS Survey Measure Activities to the Quality, Timeliness, and Access Domains

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

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

7. Behavioral Health Member Satisfaction Survey

Results

HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, HUM's members were not eligible to be surveyed, and results for HUM are not included in the SFY 2023 EQR technical report. Results for HUM will be included in the SFY 2024 EQR technical report.

Methodology

Objectives

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

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom behavioral health member satisfaction survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from July to September 2023.

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

For the global rating, HSAG calculated the percentage of respondents who chose a positive experience rating (i.e., a response of 9 or 10 on a scale of 0 to 10). For the composite measure, HSAG calculated the percentage of respondents who chose a positive response. The composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measure was a response of "Usually" or "Always." For the individual item measures, HSAG calculated the percentage

of respondents who chose a positive response (i.e., "Usually/Always," "Yes," "A lot," or "Not a problem").

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care and services provided by the MCOs, HSAG assigned the measures evaluated in the behavioral health member satisfaction survey to one or more of these three domains. This assignment to domains is shown in Table 7-1.

Table 7-1—Assignment of Behavioral Health Member Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
How Well People Communicate	✓		
Cultural Competency	✓		
Helped by Counseling or Treatment	✓		

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

8. Case Management Performance Evaluation

Introduction

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

Activities Conducted During SFY 2023

During SFY 2023, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG will conduct the focus study, which will commence in SFY 2024, in accordance with CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[8-1]

At the time of this report, the CMPE had not been completed. Results, including conclusions, strengths, and opportunities for improvement, will be reported in the SFY 2024 EQR technical report.

Methodology

Objectives

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

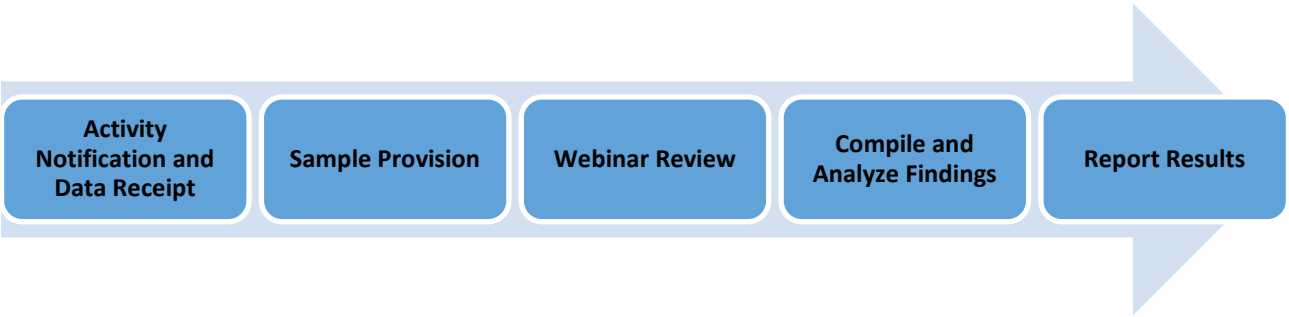
HSAG's CMPE review tool will comprehensively address the services and supports that are necessary to meet enrollees' needs. The tool will include elements for review of CM documentation and enrollee care

[8-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 19, 2023.

plans to ensure that they are consistent with a person-centered approach to care planning and service delivery and that outcomes are being achieved or progress is being made toward their achievement. The CMPE review tool will include MCO contract requirements, evaluation criteria of those requirements, and reviewer determinations of performance.

Review Process

HSAG's CM Review process will include five activities:



Activity 1: Activity Notification and Data Receipt

To initiate the CM Review, HSAG will conduct an activity notification webinar for the MCOs. During the webinar, HSAG will provide information about the activity and expectations for MCO participation, including provision of data. HSAG will request the LA PQ039 Case Management report from each MCO.

Table 8-1—Activity 1: Activity Notification and Data Receipt

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

Activity 2: Sample Provision

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

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

Enrollees who are identified by the MCOs for CM but not enrolled will be excluded from the sample. HSAG will exclude any enrollees identified in the "members identified, but not enrolled" field in the LA PQ039 Case Management report.

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

Based on the inclusion criteria, HSAG will generate a random sample of 110 enrollees for each MCO, which includes a 10 percent oversample to account for exclusions or substitutions. HSAG will provide each MCO with its sample 10 business days prior to the webinar review. The MCO will be given five business days to provide HSAG with any requests for exclusions or substitutions. If the oversample is not large enough to obtain the necessary sample size, HSAG will select additional random samples to fulfill the sample size. The final sample of cases (100 total) will be confirmed with the MCO no later than three business days prior to the webinar review.

Table 8-2—Activity 2: Sample Provision

For this step,	HSAG will…
Step 1:	**Identify enrollees for inclusion in the sample.**
	HSAG will utilize the data provided in each MCO's LA PQ039 Case Management report.
Step 2:	**Provide the sample to the MCOs.**
	HSAG will provide the 100-enrollee sample and 10-enrollee oversample to each MCO 10 business days prior to the webinar review. The sample will be provided via HSAG's SAFE site.
Step 3:	**Finalize the sample.**
	The MCOs will provide HSAG with any requests for exclusions or substitutions to the sample within five business days of receipt of the sample file from HSAG. HSAG will provide the final sample of 100 enrollee cases to each MCO no later than three business days prior to the webinar.

Activity 3: Webinar Review

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

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

The webinar review consists of several key activities:

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

Table 8-3—Activity 3: Webinar Review

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

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

Scoring Methodology

HSAG will use the CM Review tool to record the results of the case reviews. HSAG will use a two-point scoring methodology. Each requirement will be scored as *Met* or *Not Met* according to the criteria identified below. HSAG will also use a designation of *NA* if the requirement is not applicable to a record; *NA* findings will not be included in the two-point scoring methodology.

Met indicates full compliance defined as the following:

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

Not Met indicates noncompliance defined as either of the following:

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

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

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

Reporting of Abuse, Neglect, or Exploitation (ANE)

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

Activity 4: Compile and Analyze Findings

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

Domain and Element Performance

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

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

Analysis of findings will include identification of opportunities for improvement.

Activity 5: Report Results

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

How Conclusions Were Drawn

Upon completion of the activity, HSAG will provide results for each MCO in three performance domains: Assessment, Care Planning, and Enrollee Interaction and Coordination of Services. Each domain includes scored elements, displayed in Table 8-4, which demonstrate each MCO's compliance with contractual requirements.

Table 8-4—Assignment of CMPE Measures to the Quality, Timeliness, and Access Domains

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

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

Results

HUM was not included in the analysis as the MCO did not start providing coverage until MY 2023. HUM will be included in future health plan report cards.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the five Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. The 2023 Health Plan Report Card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection

HSAG received MY 2022 CAHPS member-level data files and HEDIS IDSS data files from LDH and the five MCOs. The *HEDIS MY 2022 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2022 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Description of Data Obtained

HSAG received the final, auditor-locked HEDIS IDSS data files from each of the MCOs, as well as the CAHPS member-level data files and summary reports. HSAG also downloaded the 2022 (MY 2021) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[9-1]

[9-1] 2022 (MY 2021) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by October 1, 2023, and 2023 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were not available until September 29, 2023.

How Data Were Aggregated and Analyzed

Using the HEDIS and CAHPS measure results for each MCO, HSAG calculated MCO ratings in alignment with NCQA's 2023 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[9-2]

- Overall
- Consumer Satisfaction
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan Services
- Prevention
  - Children and Adolescent Well-Care
  - Women's Reproductive Health
  - Cancer Screening
  - Other Preventive Services
- Treatment
  - Respiratory
  - Diabetes
  - Heart Disease
  - Behavioral Health—Care Coordination
  - Behavioral Health—Medication Adherence
  - Behavioral Health—Access, Monitoring, and Safety
  - Risk-Adjusted Utilization

For each measure included in the 2023 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2022 (MY 2021) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 9-1. For the *Plan All-Cause Readmissions* measure, HSAG followed NCQA's methodology for scoring risk-adjusted utilization measures.

Table 9-1—Measure Rate Scoring Descriptions

Score	MCO Measure Rate Performance Compared to National Benchmarks
5	The MCO's measure rate was at or above the national Medicaid ALOB 90th percentile.
4	The MCO's measure rate was at or between the national Medicaid ALOB 66.67th and 89.99th percentiles.

[9-2] National Committee for Quality Assurance. 2023 Health Plan Ratings Methodology. Available at: https://www.ncqa.org/wp-content/uploads/2022/12/2023-HPR-Methodology_12.14.2022.pdf. Accessed on: Dec 19, 2023.

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

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 2023 Health Plan Ratings. For each composite and subcomposite, HSAG calculated scores using the following equation:

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

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

For the Overall Rating and each composite/subcomposite rating, HSAG aligned with NCQA's rounding rules and awarded scores as outlined in Table 9-2.

Table 9-2—Scoring Rounding Rules

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

How Conclusions Were Drawn

For the 2023 Health Plan Report Card, HSAG displayed star ratings based on the final scores for each rating. Stars were partially shaded if the MCO received a half rating (e.g., a score of 3.5 was displayed as 3.5 stars).

10. MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2023 to comprehensively assess HUM's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides HUM's strengths, opportunities for improvement, and recommendations in Table 10-1 through Table 10-3.

Table 10-1—Strengths Related to Quality, Timeliness, and Access

Overall MCO Strengths	
Quality and Access	• HUM had several high PDV match rates, including the address indicator for pediatrics and behavioral health, the provider affiliation indicator for OB/GYN providers, and new patient acceptance indicator for OB/GYN providers. Correct address and provider information and accurate new patient acceptance are crucial for members to locate providers when seeking care.
Access	• HUM achieved GeoAccess results above 99 percent for rural behavioral health specialists, rural behavioral health prescribers, and urban and rural inpatient psychiatric providers.

Table 10-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall MCO Opportunities for Improvement	
Quality and Access	• The results of two EQR activities indicate opportunities for HUM to improve access to care for its members. HUM did not meet any GeoAccess standards, and the provider directory information maintained and provided by HUM was poor.

Table 10-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
HUM should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.	Goal 1: Ensure access to care to meet enrollee needs Goal 6: Partner with communities to improve population health and address health disparities
For provider types that did not meet GeoAccess standards, HUM should contract with additional providers, if available, or continue to implement strategies for expanding the provider network such as enhanced reimbursement or encouraging providers to expand licensing to add additional ASAM LOCs. HUM should also conduct an in-depth review	Goal 1: Ensure access to care to meet enrollee needs Goal 6: Partner with communities to improve population health and address health disparities

Overall MCO Recommendations	
of provider types for which GeoAccess standards were not met and evaluate whether offering additional telehealth services could increase compliance with GeoAccess standards.	

11. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. However, HUM was a new MCO to Louisiana Medicaid as of January 1, 2023; therefore, HUM did not have prior year recommendations from the EQRO.

Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from HUM's Health Equity Plan (HEP) submission from February 2023.

Health Equity Plan

HSAG reviewed HUM's HEP submitted February 2022. In the section titled "RFP Response Related to Proposed Health Equity Approach and Experience to Date," HSAG summarized and organized each MCO's response into the following topics, for comparison among MCOs—Stated Goals; Policies and Procedures; Staffing and Resources; Leveraging Data; Social Determinants of Health; and Community, Provider, and Member Engagement Initiatives. For the other sections of the HEP, HSAG organized the discussions in this report as each MCO presented the topics in its own HEP. Therefore, comparison across MCOs for the "Health Equity Plan Development Process," "Health Equity Action Plan by Focus Area," "Plan to Conduct Cultural Responsiveness and Implicit Bias Training," and "Stratify MCO Results on Attachment H Measures" sections of the HEP is not possible.

RFP Response Related to Health Equity Approaches and Experience

HSAG summarized and organized HUM's Request for Proposal (RFP) responses into a standard set of topics as follows:

Stated Goals

HUM reported the following programmatic goals in its HEP:

- Integrate Health equity into all aspects of organizational operations.
- Ensure that cultural sensitivity and racial empathy are integrated into the design of all HUM's programs, products, and services.

Policies and Procedures

HUM reported the following organizational policies and procedural program components:

- HUM will pursue the NCQA Health Equity Accreditation for the Louisiana plan.
- Policies and Procedures will reflect organizational practices to ensure Culturally and Linguistically Appropriate Services (CLAS).
- HUM's Concierge Service for Accessibility provides interpreters and alternative formats to members who require or indicate a preference for communications to be delivered in a non-English language and works to proactively resolve any barriers to care.

  - Members can self-refer to the Concierge Service for Accessibility or be referred by a HUM associate, provider, or community partner.
  - Once a member requests an alternative format, all future communications are sent in this format.
  - When possible, members are assigned Case Managers who speak their preferred language.
  - Translation and interpretation services are available in more than 200 languages, including American Sign Language (ASL).
- HUM's Network Development Plan prioritizes recruiting diverse providers who align with the cultural preferences of members.
- HUM's Community and Member Advisory Board will be merged with the current Member Advisory Committee.

Staffing and Resources

HUM reported the following:

- HUM has named a Louisiana Health Equity Administrator, who will foster the integration of HUM's and LDH's health equity goals.
- Strategies to recruit Personnel include hiring Louisiana-based associates across every region of the State to reflect the linguistic and cultural needs of HUM's expected membership.
- Strategies to retain personnel include engaging associates in feedback forums and engagement strategies that enhance HUM's operations; promoting participation in Network Resource Groups; conducting internal reviews and external market benchmarking of associate pay.
- Strategies to promote HUM's Talent Ready Pipeline program prepares diverse associates for promotion through mentorship opportunities.
- Develop and monitor completion of training materials.
- HUM requires all new associates to complete cultural competency trainings, which include modules on cultural sensitivity and responsiveness, CLAS standards, and health equity.
- HUM Healthy Horizons will partner with the Rhodes College Institute for an Equity Scholarship to develop region-specific training for HUM associates.
- HUM will conduct training via Sista Midwife Productions for HUM Beginnings maternity care management teams on the causes, warning signs, and advocacy techniques for Black women at risk for maternal morbidity and mortality.
- HUM will evaluate the feasibility of combining HUM's pregnancy programs with pilot the model.

Leveraging Data

HUM reported the following:

- Use an approach to health equity that is highly localized and data driven.

- Data collection related to members' race, ethnicity, language, and disability (RELD) status and geography ("RELD-G").
- HUM collects RELD-G and gender data through the comprehensive health needs assessment (HNA), interactions with member-facing staff, a self-reporting form available through the online member portal, intake forms for clinical programs, and data received from providers.
- HUM will use member RELD-G and gender data to ensure CLAS are appropriately serving HUM's membership.
- Conduct ongoing monitoring of HUM's provider network to ensure cultural responsiveness, and tailor member engagement strategies.
- HUM will stratify data by gender identity where data are available and incorporate RELD-G and gender data into the development of programs and initiatives.
- HUM will stratify member data by all demographic factors, including RELD-G and gender, zip code, and provider group; and use heat mapping, which enables HUM to analyze membership from a variety of perspectives and define populations for interventions.
- Identify gaps in care delivery, quality of care issues, or disparities in outcomes to allow the Data and Analytics team to perform a root cause analysis (RCA) to identify why issues occur and create a targeted solution.
- HUM will use Population Health Suite to analyze data across systems.
- HUM will leverage data analysis and community input to address outcome inequities.
- HUM will use satisfaction data collected through CAHPS surveys and will oversample identified minority groups if the initial results provide inadequate information to draw conclusions to inform programming.

Social Determinants of Health

HUM reported the following:

- All Medicaid associates participate in HUM's Poverty Simulator Experience, which trains associates on the experiences of families living at or below the poverty level.
- HUM combines data from disparate sources, enabling identification of both disparities and contributing social factors.
- HUM will partner with community-based organizations (CBOs), providers, and LDH to develop training on institutional racism and how to address racial bias and unconscious bias.
- Community Health Workers (CHWs) will target high-risk and "unable-to-contact" members to connect them to available resources.
- Peer Support Specialists (PSSs) will assist with identifying resources to address social determinants of health (SDOH).
- HUM will develop health education materials in the most prevalent languages within each parish, distributing them to local providers and CBOs.

Community, Provider and Member Engagement Initiatives

HUM reported the following:

- HUM engaged with over 100 stakeholders across every region of the State as part of HUM's Health Equity Listening Tour, learning about regional challenges and nuances faced by the State's diverse populations.
- HUM maintains partnerships with Historically Black Colleges and Universities (HBCUs), including Louisiana State University (LSU)-Eunice, Xavier University, and Grambling State University, to connect students to paid internships and full-time employment opportunities.
- HUM provides scholarships to Louisianans pursuing a career in health sciences or a health-related professions.
- HUM provides education and training on CLAS to providers.
- HUM will make its Practice Transformation Fund available to providers to enhance their language and accessibility services such as hiring bilingual staff or interpreters.
- HUM's provider engagement team collaborates with quality and provider performance improvement teams to develop trainings with sessions on cultural competency, health equity, and implicit biases.
- HUM will engage community members through the Member Advisory Committee (MAC), listening sessions, and by obtaining ongoing feedback through member- and community-facing associates' CBO partner locations across the State.
- The Community Engagement team will conduct targeted outreach to members to promote participation in the MAC.
- HUM will administer a Member Experience Survey to members following postpartum visits to assess their satisfaction with their care.
- HUM will host Provider Advisory Council (PAC) meetings and will ensure that PAC participation includes a variety of provider types.
- HUM will identify key providers serving underrepresented and priority populations, and conduct targeted outreach to promote participation in the PAC.
- HUM will host one MAC and one PAC per quarter (eight total meetings annually) in different regions with an option to join meetings remotely.
- HUM will partner with New Orleans East Hospital to pilot a program through which CHWs will accompany pregnant members to appointments and help them establish pediatric care prior to delivery.
- HUM will connect members with behavioral health needs to in-person PSSs to assist with recovery planning, skill building, counseling, relapse prevention, and health education.
- HUM will pilot the Daddy Doula Program with The Family Tree in Lafayette.

- HUM has established specific activities to engage diverse community voices to help inform the organization's approach to delivering culturally appropriate and equitable care to Louisianans:
  - HUM will conduct landscape analysis to identify priority populations, stakeholders, and organizations for engagement.
  - HUM's Community and Provider Engagement teams monitor participation rates and engagement strategies to ensure committees effectively assemble a representative set of perspectives that match the diverse needs of HUM's members.
  - HUM will partner with Volunteers of America to develop a Family Focused Recovery (FFR) program for pregnant members with substance use disorders (SUDs).
  - HUM will deploy mobile health units to provide key preventive and dental care, including well-child visits and vaccinations, at local schools and community centers, targeting rural areas, underserved urban communities, and areas with a high concentration of care gaps.
  - HUM will seek to convene LDH and Louisiana Head Start grantees to develop and disseminate a culturally appropriate health education campaign for members and their families.
  - HUM will emphasize the importance of routine preventive dental care in its provider outreach and education approach.

Health Equity Plan Development Process

HUM reported completing the following steps to develop the HEP:

- In August and September 2021, HUM partnered with the Urban League of Louisiana, the Legislative Black Caucus, and the Southern Poverty Law Center to conduct eight community listening sessions across the State.
- In May and June of 2022, HUM partnered with the March of Dimes, Sista Midwife Productions, and the Amandla Group to host listening sessions with:
  - Black women from New Orleans who have given birth within the past five years.
  - People from the LGBTQIA+ community.
  - Rural Louisianans.
- Address feedback when developing programs to ensure health equity.
- Ensure the HEP addresses the following goals and objectives:
  - Ensure that the core strategies of the HEP include authentic community engagement and data-driven practice.
  - Ensure that HUM's services are delivered in a culturally appropriate and effective manner to all members.
  - Continuously leverage feedback from MAC and PAC, CAHPS surveys, and listening sessions to inform the ongoing development and delivery of programs and services.
  - Administer the CAPHS Survey to HUM's members in 2023 and review the results of the surveys with the MAC in Q3 2024.

- Ensure the HEP continues to employ the following programmatic components and priorities:
  - Every member-facing associate completes a self-paced, online curriculum to increase understanding and awareness of cultural competency during their initial orientation. This introduces the learner to the impact of cultural competency in healthcare.
  - Orientation topics include culture/subculture, "ethno-culture," language, religion/spiritual beliefs, regional subculture, LGBTQIA+ community, military veterans, and other underserved populations.
  - HUM associates will receive more in-depth education with Rhodes College Institute for Equity and Public Scholarship and participate in facilitated small-group discussions on cultural humility and implicit biases, and how these impact policy and processes.
  - Providers have access to trainings on cultural responsiveness and implicit bias through HUM's provider orientation and are required to complete these trainings withing 30 days of contracting with HUM.
  - Partner with LDH and other MCOs to offer more in-depth training on heath equity and implicit bias.
  - Test potential publications with enrollees for understanding and conveyance of the intended message, as well as cultural appropriateness.
  - Partner with CBOs to address SDOH -related needs, including ensuring the active referral to and follow-up on identified needs related to SDOH.
  - Implementing findhelp.org as an SDOH resource guide and platform to make closed loop referrals between members, the care management team, providers, and CBO partners.
  - Member Call Center staff, care managers, and CHWs screen for SDOH as part of the HNA upon member enrollment and can make secure referrals for SDOH.
  - Pilot a process to work with providers to train their staff to screen for SDOH needs, submit Z codes on claims, so HUM can reimburse for SDOH screenings and referrals.

Health Equity Action Plan by Focus Area

Table A-1 describes HUM's focus areas, goals and objectives, strategies, activities planned, and participants needed to address each focus area:

Table A-1—Addressing Focus Areas

Focus Area	Goals	Objectives	Strategies	Activities	Participants
A. Ensure the Delivery of Services in a Culturally Appropriate and Effective Manner	• Identify and implement action plans that achieve measurable reductions in health disparities	• By June 2024: – Develop CLAS work plan – Pursue NCQA Health Equity Accreditation	• Ensure that HUM associates and providers follow CLAS Standards and pursue NCQA Health Equity Accreditation	• Implement and oversee the annual CLAS work plan • Train staff to identify members with limited English proficiency (LEP)	• Medicaid Quality Improvement Governance Committee (QIGC) • Director of quality

Focus Area	Goals	Objectives	Strategies	Activities	Participants
				and provide appropriate telephonic interpretation and/or written translation services • Pursue NCQA Health Equity Accreditation and align staff and leadership in reducing health disparities • Ensure that equity is core to HUM's mission and values • Offer guidance on assessing and addressing SDOH	• Director of health equity
B. Engage Diverse Families to Design Services and Interventions that Integrate Care and Address Childhood Adversity and Trauma	• Facilitate presentations for the Member Advisory Committees (MACs)	• Adverse Childhood Events (ACE) presentations offered to MAC members by March 2024	• Use feedback from MAC meetings to develop, pilot, implement, and refine interventions that address ACEs	• Collaborate with the LDH Partners for Family Health ACE Initiative • Convene focus groups to develop, pilot, implement, and refine interventions that address trauma	• MAC • LDH Bureau of Family Health ACE educators
C. Obtain and Incorporate Input from Members who have Disparate Outcomes	• Determine which services are working well • Identify gaps • Improve access, quality, and outcomes • Promote equity	• By June 2024: – Listening sessions – MAC meetings – Review CAHPS survey data as available	• Incorporate member feedback to inform development, and make quality improvements based on the feedback	• Hold listening sessions • Seek feedback through the MACs, and through Member Experience surveys via telephone, text, email, mail, and	• MAC members

Focus Area	Goals	Objectives	Strategies	Activities	Participants
			• Use CAHPS surveys, clinical program surveys, Voice of the Consumer surveys (after call center interactions), and routine pulse surveys • Oversample members with disparate outcomes, if needed	during outreach events	
D. Ensure that Members Test Outward Facing Materials for Understanding and Cultural Appropriate-ness	• Meet members' cultural, linguistic, and accessibility needs	• Review and revision of marketing and member education materials by the MACs by June 2024	• Develop member materials based on health literacy and plain language standards	• Use the Flesch-Kincaid tool to ensure that written member materials can be easily read by members • Write all materials at no higher than a 6.9 grade level • Test all outward-facing communications with members of the MAC and/or through marketing focus groups • Provide member materials in multiple languages and formats	• MAC members

Focus Area	Goals	Objectives	Strategies	Activities	Participants
E. Partner with CBOs to address SDOH-Related Needs	• Ensure that members have access to services to address SDOH • Identify community-based resources and close the loop on referrals to those resources	• By June 2024: – At least 10 CBOs will participate in training on findhelp.org – Findhelp.org training for Care Managers, CHWs, PSSs, and CBOs	• Coordinate between CM, CHWs, and/or PSS, and CBOs	• Train CM staff, CHWs, PSSs. and CBOs • Pilot SDOH screening and referral to community-based services with provider groups	• Care managers • CHWs • PSSs • CBOs • Providers
F. Recruit, Develop and Promote Diverse Talent at HUM	• Retain employees • Promote leadership, inclusion, and career advancement for individuals from under-represented communities • Create agents for advocacy • Equip associates with experience to prepare for a future promotion • Mentor associates	• By June 2024 increased number of: – Diverse recruitment events attended by associates – Associates participating in NRGs – Associates in pipeline program and mentoring circles – Students from under-represented groups who receive stipends	• Recruit, develop and promote diverse talent for HUM's team	• Partner with historically Black colleges and universities the Hispanic Chamber of Commerce, the Asian Chamber of Commerce, regional Chambers of Commerce, and the Louisiana Association of Business and Industry to recruit associates who reflect the geographic, racial, ethnic, gender, and language diversity of the State. • Connect Louisiana associates to HUM's national Network Resource Groups (NRGs)	• Health Equity staff • Population Health staff • Community Engagement team • Human Resources staff

Focus Area	Goals	Objectives	Strategies	Activities	Participants
				• Pair program managers with diverse internal associates who are ready for immediate promotion or a developmental move	
G. Develop a Pipeline for Diverse Health and Social Service Providers	• Offer stipends and internship opportunities to diverse undergraduate and graduate students in health and social service professions	• By June 202 increase the number of: – Students who complete internships – Students from RELS-G groups who receive stipends from HUM	• Support a pipeline of diverse health and social service professionals who can meet community needs	• Develop community Partnerships • Collaborate with LSU-Eunice, Grambling State University, Xavier University, Southern University, and Dillard University	• Health Equity staff • Population Health staff • Community Engagement team • Human Resources staff
H. Support Members through Diverse CHW, PSS, and Doula Programs	• Promote health equity • Improve maternal and child health outcomes • Train PSS • Offer scholarships to Healthy Start Program participants for doula training, including fathers who are interested in receiving doula training	• By June 2024: – Launch New Orleans East Community Health Work Pilot Project – Trian two CHWs for practice at New Orleans East hospital – Train two PSS – Launch Family Tree Doula Pilot – Increase number of New Orleans East Hospital CHW visits to pregnant/ postpartum women	• Support evidence-informed para-professional support models	• Pilot a CHW program with New Orleans East Hospital • Train CHWs through a rigorous certification that includes education on health disparities, cultural humility, and implicit bias • Partner with the Louisiana Office of Behavioral Health (OBH) • Partner with the Mental Health Association of Greater Baton Rouge	• CHWs • PSS • Daddy Doulas

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		– Increase number of Daddy Doulas who receive certification and number of Daddy Doula visits		• Partner with Family Tree in Lafayette	
I. Reduce Maternal and Child Health Disparities for Black Members and their Newborns	• Reduce the stark disparities in pregnancy and birth outcomes for Black women in Louisiana • Promote participation in the Member • Reduce the health inequities faced by pregnant and new mothers • Assess member satisfaction with care	• By December 2023: – Family Tree Daddy Doula pilot – Establish home visiting services through findhelp.org – New Orleans East Hospital CHW pilot – Improve performance measure rates related to maternal health	• Work with members, providers, and other stakeholders.	• Conduct targeted outreach to pregnant Black members. • Administer a Member Experience Survey to Black mothers following postpartum visits • Partner with Volunteers of America • HUM will expand its FFR program with Volunteers of America into Louisiana in 2024. • Connect pregnant women to the *Humana Beginnings* care management services as well as existing community-based programs • Develop and scale a FFR program for pregnant members with SUDs nationwide	• Member Advisory Committee • Health Equity staff • Population Health staff • Community Engagement Team

Focus Area	Goals	Objectives	Strategies	Activities	Participants
J. Improve Child and Adolescent Health	• Improve child and adolescent health • Engage parents, guardians, parental custodians, and adolescents • Increase well-child visits and immunization rates • Offer health education, well-child visits, and immunizations • Expand access to preventive dental services	• Improve performance measure rates related to child and adolescent health by June 2024	• Partner with members, providers, and CBOs	• Work with Community Health Workers and the Community Engagement team to do in-person outreach • Collaborate with Ochsner Health • Deploy two mobile health units and establish three community-based health clinics in underserved areas • Partner with School Based Health Centers, Head Start, and Federally Qualified Health Centers	• Member Advisory Council • EPSDT Coordinator • Health Equity staff • Population Health staff • Community Engagement Team • CBO partners

Plan to Conduct Cultural Responsiveness and Implicit Bias Training

HUM reported the following activities designed to conduct cultural responsiveness and implicit bias training:

- Partner with the Rhodes College Institute for Equity and Public Scholarship to provide the following training sessions:
  - Unit 1: "Justice is Part of the Job: Cultivating Structural Competence to Reduce Agency Bias"
  - Unit 2: "Understanding Bias: Developing Skills for Equity-Oriented Person-Centered Care"
- Remote one-hour small-group discussions led by the Institute facilitators
- Online chat with facilitators and participants from small-group discussions

Stratify MCO Results on Attachment H Measures

HUM reported that, when data are available in 2023, it will summarize baseline information, and stratify data by RELD-G quarterly; review the data with the MAC; and implement outreach, engagement, and improvement plans based on the outcomes.