LOUISIANA DEPARTMENT OF HEALTH

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

External Quality Review Technical Report

for

Louisiana Healthcare Connections

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Acknowledgments and Copyrights

1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral 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	✓	N/A	N/A
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 Louisiana Healthcare Connections (LHCC) 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, LHCC, and other MCOs in transitioning to HSAG's PIP validation process and methodology. LHCC actively worked on PIPs throughout SFY 2023, and PIP validation activities were initiated. LDH required LHCC 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 LHCC'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

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

Information Systems Capabilities Assessment

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

HEDIS—Quality, Timeliness, and Access

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2022 NCQA national 50th percentile, which served as the benchmark. A total of 47 measures, comprising 89

measure indicators, were selected for analysis. Of the 89 measure indicators, 11 were not reported in Quality Compass and were therefore removed from the respective analyses due to lack of a benchmark.

Of the 78 HEDIS measures/measure indicators with an associated benchmark, LHCC had 27 that performed greater than the NCQA national 50th percentile benchmark, and 51 that performed lower than the NCQA national 50th percentile benchmark. Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

In HSAG's CR, LHCC received a compliance score of 85.7 percent for Standard I—Enrollment and Disenrollment, indicating that, overall, LHCC has improvement to make in compliance with this standard.

HSAG also reviewed LHCC's corrective action plans (CAPs) from the LDH-approved 2022 CR. LHCC achieved compliance in 22 of 24 elements from the 2022 CAPs, demonstrating positive improvements in implementing CAPs from 2022. LHCC must implement the remaining approved CAPs for the two elements for which compliance was not achieved.

Validation of Network Adequacy

HSAG's provider directory validation (PDV) indicated that, overall, the provider information maintained and provided by LHCC 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.

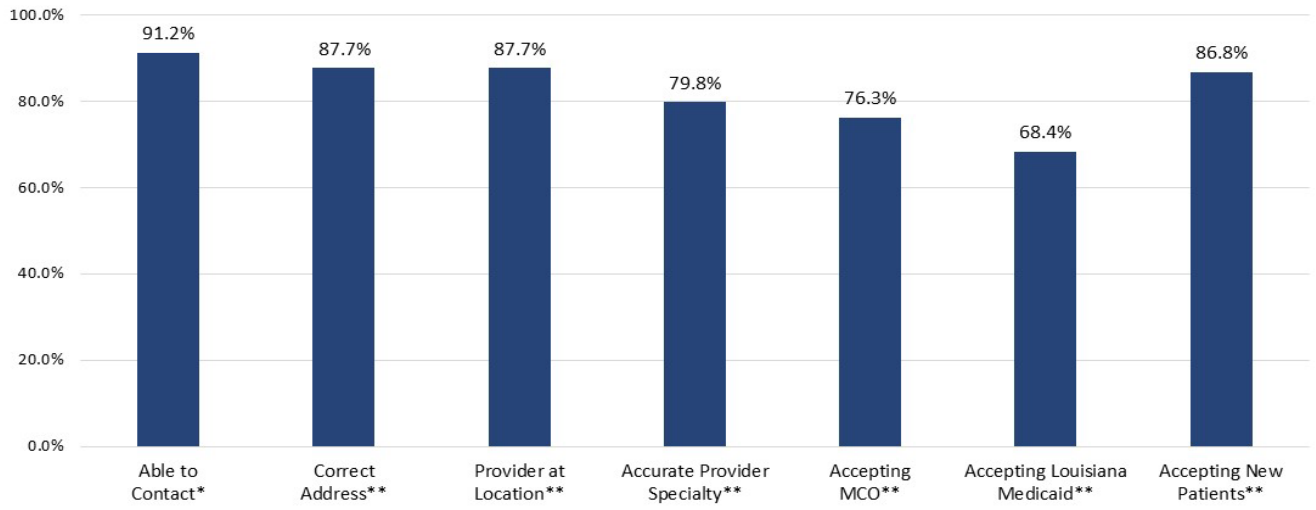
Table 1-3—Summary of Findings

Concerns	Findings
Acceptance of Louisiana Medicaid was inaccurate.	Overall, 68.4 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was inaccurate.	Overall, 76.3 percent of providers accepted the requested MCO.
Provider's specialty in the provider directory was incorrect.	Overall, 79.8 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall acceptance of new patients was low.	Overall, 86.8 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, 87.7 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 87.7 percent of respondents reported that LHCC's provider directory reflected the correct address.

While the overall PDV response rate was relatively high at 91.2 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of the provider's specialty, Louisiana Medicaid acceptance, and LHCC acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate below 88.0 percent.

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

Figure 1-1—Summary Results for All LHCC Providers



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

LHCC's weighted PDV compliance scores by specialty type ranged from 37.3 percent (behavioral health) to 85.3 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), LHCC reported the percentage of members having access within required distance standards for 22 physical health provider types and 19 behavioral health provider types. Data were reported for a total of 32 physical health GeoAccess standards (10 of the physical health provider types were reported separately for the urban and rural populations) and 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, LHCC only met three of 32 physical health GeoAccess standards (though 20 were 99 percent or higher) and one of 34 behavioral health GeoAccess standards.

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared LHCC's 2023 achievement scores to their corresponding 2022 achievement scores and the 2023 NCQA national averages to determine whether there were statistically significant differences.

Overall, LHCC's 2023 achievement scores did not reveal strengths in the adult and general child populations as LHCC's 2023 achievement scores were not statistically significantly higher in 2023 than in 2022 or statistically significantly higher than the 2023 NCQA national average on any measure.

Furthermore, opportunities for improvement were not identified for LHCC's adult and general child populations, as LHCC's 2023 achievement scores were neither statistically significantly lower in 2023 than 2022 nor statistically significantly lower than the 2023 NCQA national average on any measure.

Behavioral Health Member Satisfaction Survey

HSAG compared LHCC's 2023 achievement scores to the 2023 Healthy Louisiana statewide average (SWA) to determine whether there were statistically significant differences. Overall, LHCC's adult and child 2023 scores were not statistically significantly higher or lower than the Healthy Louisiana SWA; therefore, no strengths or opportunities for improvement were identified. However, several measures had less than 100 respondents. LHCC should focus on increasing response rates to the behavioral health member satisfaction survey for its adult and child populations.

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. The 2023 Health Plan Report Card shows that, for the Overall Rating, LHCC received 3.0 stars. LHCC had the lowest performance on the 2023 Health Plan Report Card compared to the other MCOs, and LHCC did not receive any 4.0 or 5.0 star ratings. LHCC received 2.0 stars for the Children and Adolescent Well-Care subcomposite. LHCC also received 2.0 stars and 1.5 stars for the Diabetes and Behavioral Health—Care Coordination subcomposites, respectively, demonstrating opportunities for improvement for LHCC in these areas.

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. LHCC actively worked on PIPs throughout SFY 2023, and HSAG initiated validation activities for LHCC's PIPs. At the time this report was drafted, HSAG's first validation cycle of the LHCC'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 LHCC, to carry out PIPs to address five state-mandated topics during SFY 2023. Table 2-1 summarizes the PIP topics carried out by LHCC 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, LHCC collaborated on improvement strategies, meeting at least monthly with LDH and other MCOs, throughout the year. LHCC also submitted updates on improvement strategies and interim indicator results for each PIP topic quarterly that were reviewed by HSAG and LDH. HSAG provided feedback and technical assistance on PIPs to LDH and LHCC at group and one-on-one meetings throughout the contract year.

Table 2-2 summarizes key PIP validation milestones that occurred from 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, LHCC 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 LHCC's PIP validation results and confidence ratings. The initial validation cycle for LHCC'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 2024
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	To be reported in SFY 2024	To be reported in SFY 2024
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 2024
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

LHCC will report final calendar year (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	Remeasurement 1
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	Remeasurement 1
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	Remeasurement 1
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	Baseline
Screening for HIV Infection	Baseline

Interventions

LHCC will report final 2023 QI activities and interventions in January through March 2024. Table 2-5 includes barriers and interventions LHCC initially reported early in the validation cycle initiated at the end of SFY 2023. LHCC will report updated QI activities and interventions in SFY 2024, and HSAG will complete the assessment of LHCC's QI activities and interventions when the validation cycle is completed in SFY 2024. An updated summary of LHCC'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 LHCC for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions in Care	• Limited behavioral health provider participation in admissions, discharges, and transfers (ADT) feeds/applications • Lack of engagement from members with substance use disorders (SUD) in follow-up care	• Enhance hospital-to-MCO workflow for notification of hospital ADTs • Linkage to aftercare with behavioral health providers prior to discharge from hospital

PIP Topic	Barriers	Interventions
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to COVID-19 vaccine • Challenges with reaching a large volume of eligible members via CM outreach alone	• COVID-19 vaccination outreach to enrollees engaged in CM and to enrollees not engaged in CM • Distribution of eligible enrollee lists and vaccination site lists to providers and facilitate referrals
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of primary care provider (PCP) training in varnish application • Lack of enrollee parent/guardian understanding of need to establish a dental provider	• Targeted member outreach and education on dental appointment scheduling for members in CM and members identified as having disparities (Geographic Region 1, Geographic Region 8, Hispanic ethnicity, and 6–18 months of age) • Community partnership with mobile units for dental exams and fluoride varnish treatments • Provider outreach and education using care gap report
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Lack of provider knowledge of proper coding to capture screening	• Targeted enrollee educational outreach on cervical cancer screening • Outreach for members with no cervical cancer screening and aiding with appointment scheduling • Provider outreach and education on CCS guidelines, billing guidelines, and the use of care gap reports to identify members eligible for CCS
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening • Enrollee's lack of transportation to screening appointments	• Outreach to pregnant members providing education on recommendations for HIV screening • Outreach for member assistance with scheduling an appointment and transportation

MCO Strengths, Opportunities for Improvement, and Recommendations

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

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

Based on a review of the FARs issued by LHCC's independent certified HEDIS compliance auditor, HSAG found that LHCC fully met the standard for five of seven of the applicable NCQA IS standards. LHCC met the standard for the remaining two of the seven applicable NCQA IS standards; however, findings were noted as they relate to IS 5.5, IS 6.3, and IS 6.5. The findings are as follows:

- *IS 5.0 Supplemental Data:* Standard was met; however, IS 5.5 was partially met, as the corporate generated supplemental data system reports showed that multiple supplemental data systems were found to have no impact upon intended HEDIS measure rates. The corporate team did not perform consistent oversight and validation over vendors.
- *IS 6.0 Data Preproduction Processing:* Standard was met; however, IS 6.3 and 6.5 were partially met, as multiple issues were encountered at the enterprise level due to incorrect extraction of data fields; delays in recognizing and/or remediating the underlying issues; and improper identification of populations, utilization data extracts, and measure reporting set selection.

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

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

IS Standard	LHCC
IS 1.0 Medical Services Data	Met
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Processes	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met

Performance Measures

For SFY 2023, LDH required each contracted MCO to collect and report on 47 HEDIS measures, which includes 89 total measure indicators for HEDIS MY 2022 specified in the provider agreement. The measurement set includes 11 incentive measures. Table 3-2 displays the 89 measure indicators required by LDH. **Red** cells indicate that the measure fell below the NCQA national 50th percentile, **green** cells indicate that the measure was at or above the NCQA national 50th percentile. Table 3-2 through Table 3-5 display a summary of LHCC's HEDIS measure performance.

Table 3-2—LHCC HEDIS Effectiveness of Care Measures—MY 2022

HEDIS Measure	LHCC	SWA
Follow-Up After Hospitalization for Mental Illness		
Within 7 Days of Discharge	18.74%	19.52%
Within 30 Days of Discharge[I]	39.48%	38.33%
Follow-Up After Emergency Department Visit for Mental Illness		
Within 7 Days of Discharge	22.54%	22.45%
Within 30 Days of Discharge[I]	37.76%	36.52%
Follow-Up After Emergency Department Visit for Substance Use[B]		
Within 7 Days of Discharge	15.88%	17.19%
Within 30 Days of Discharge[I]	26.05%	27.70%
Plan All-Cause Readmissions*		
Observed Readmissions (Numerator/Denominator)	9.52%	10.15%
Expected Readmissions Rate	9.40%	9.57%
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.0122	1.0603
CAHPS Health Plan Survey 5.1H, Adult (Rating of Health Plan, 8+9+10)	77.08%	80.81%
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan—General Population, 8+9+10)	86.26%	86.41%
Depression Screening and Follow-Up for Adolescents and Adults		
Depression Screening (Total)	0.00%	1.00%
Follow-Up on Positive Screen (Total)	0.00%	58.25%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.52%	82.78%
Diabetes Monitoring for People With Diabetes and Schizophrenia	67.44%	67.47%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	76.84%	76.14%

HEDIS Measure	LHCC	SWA
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Blood Glucose Testing	52.04%	54.46%
Cholesterol Testing	25.42%	28.80%
Blood Glucose and Cholesterol Testing	24.73%	28.05%
Lead Screening in Children	61.64%	63.59%
Childhood Immunization Status		
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	68.13%	68.23%
Polio Vaccine, Inactivated (IPV)	89.05%	87.00%
Measles, Mumps, and Rubella (MMR)	85.16%	84.34%
Haemophilus Influenzae Type B (HiB)	84.67%	84.33%
Hepatitis B	91.00%	88.75%
Varicella-Zoster Virus (VZV)	85.40%	84.35%
Pneumococcal Conjugate	66.91%	68.57%
Hepatitis A	80.78%	80.70%
Rotavirus	67.15%	66.63%
Influenza	27.98%	26.49%
Combination 3[I]	61.80%	62.44%
Combination 7	51.82%	53.35%
Combination 10	20.92%	20.30%
Immunization Status for Adolescents		
Meningococcal	83.76%	83.48%
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	84.46%	84.30%
Human Papillomavirus (HPV)	37.60%	39.08%
Combination 1	83.59%	83.26%
Combination 2[I]	37.27%	38.69%
Colorectal Cancer Screening[I]	34.06%	33.81%
Flu Vaccinations for Adults Ages 18 to 64	35.14%	36.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
Body Mass Index (BMI) Percentile Documentation	60.58%	72.22%
Counseling for Nutrition	57.18%	62.46%
Counseling for Physical Activity	51.58%	55.47%
HIV Viral Load Suppression[B, I]	79.78%	79.04%

HEDIS Measure	LHCC	SWA
***Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)**[*,I]*	27.47%	26.61%
Chlamydia Screening in Women		
Total	63.84%	63.13%
Breast Cancer Screening	55.74%	55.83%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers to Quit	72.73%	73.05%
Discussing Cessation Medications	45.16%	48.84%
Discussing Cessation Strategies	39.52%	47.04%
***Controlling High Blood Pressure**[I]*	55.23%	57.62%
Statin Therapy for Patients With Cardiovascular Disease		
Received Statin Therapy—Total	80.41%	80.66%
Statin Adherence 80%—Total	73.30%	67.86%
Hemoglobin A1c Control for Patients With Diabetes		
*Poor HbA1c Control (>9.0%)**[*,I]*	45.99%	38.96%
HbA1c Control (<8.0%)	44.77%	52.48%
Eye Exam for Patients With Diabetes	53.04%	53.85%
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg) (BPD)	50.61%	59.93%
Pharmacotherapy for Opioid Use Disorder	34.90%	27.67%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment		
*Initiation of SUD**[B]*	55.86%	60.37%
*Engagement of SUD**[B]*	21.55%	25.62%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	60.10%	63.46%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.14%	53.17%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication		
Initiation Phase	42.92%	42.65%
Continuation and Maintenance Phase	54.84%	55.44%
Antidepressant Medication Management		
Effective Acute Phase Treatment	56.85%	55.83%
Effective Continuation Phase Treatment	39.76%	38.18%
Appropriate Treatment for Children With Upper Respiratory Infection	79.95%	79.64%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	52.58%	51.85%

HEDIS Measure	LHCC	SWA
Use of Imaging Studies for Low Back Pain[B]	71.47%	71.31%
Non-Recommended Cervical Screening in Adolescent Females[*]	2.07%	1.81%
Cervical Cancer Screening[I]	56.69%	56.53%
Self-Reported Overall Health (Adult)	26.97%	27.63%
Adult—Very Good	18.67%	18.98%
Adult—Excellent	8.30%	8.65%
Self-Reported Overall Health (Child-General)	72.20%	73.27%
Child General—Very Good	39.04%	36.17%
Child General—Excellent	33.16%	37.10%
Self-Reported Overall Health (Child-CCC)	54.64%	59.04%
Child CCC—Very Good	34.54%	36.64%
Child CCC—Excellent	20.10%	22.40%
Self-Reported Overall Mental or Emotional Health (Adult)	40.33%	38.64%
Adult—Very Good	24.28%	22.37%
Adult—Excellent	16.05%	16.27%
Self-Reported Overall Mental or Emotional Health (Child)	59.14%	65.65%
Child General—Very Good	22.04%	28.34%
Child General—Excellent	37.10%	37.31%
Self-Reported Overall Mental or Emotional Health (Child CCC)	35.42%	40.97%
Child CCC—Very Good	18.23%	24.08%
Child CCC—Excellent	17.19%	16.89%

[*] Indicates a lower rate is desirable.
[B] Indicates a break in trending between the most recent year and the prior year.
[I] Incentive Measure.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-3—LHCC HEDIS Access to/Availability of Care Measures—MY 2022

HEDIS Measure	LHCC	SWA
Well-Child Visits in the First 30 Months of Life		
First 15 Months	58.57%	59.52%
15 Months–30 Months	63.41%	63.95%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	72.25%	70.84%
45–64 Years	81.11%	80.13%
65 Years and Older	78.18%	75.93%

HEDIS Measure	LHCC	SWA
Total	74.69%	73.65%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care[C]	81.51%	82.86%
Postpartum Care[C]	75.18%	77.00%

[C] Indicates a caution in trending between the most recent year and the year prior.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-4—LHCC HEDIS Use of Services Measures—MY 2022

HEDIS Measure	LHCC	SWA
Child and Adolescent Well-Care Visits		
3–11 Years	55.24%	54.57%
12–17 Years	52.49%	51.26%
18–21 Years	27.83%	27.04%
Total	49.12%	48.34%
Ambulatory Care		
Outpatient Visits/1,000 MM	4932.72	4,930.50
Emergency Department Visits/1,000 MM[*]	736.87	746.42

[*] Indicates a lower rate is desirable.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-5—LHCC HEDIS Measures Summary—MY 2022

Measure Status	LHCC
≥ NCQA National 50th Percentile Benchmark	28
< NCQA National 50th Percentile Benchmark	50
NCQA National Benchmark Unavailable	11
Total	89

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- LHCC's performance for the *Chlamydia Screening in Women* measure ranked above the NCQA national 50th percentile benchmark and SWA. Screening for chlamydia is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-1] **[Quality]**

[3-1] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Nov 21, 2023.

- LHCC's performance for the *Pharmacotherapy for Opioid Use Disorder* measure ranked above the NCQA national 50th percentile benchmark and SWA. Pharmacotherapy has been identified as a critical part of treatment for individuals with opioid use disorder (OUD). Encouraging pharmacotherapy is critical because individuals with OUD who engage in treatment with pharmacotherapy are less likely to exhibit withdrawal or craving symptoms and use illicit opioids, and are more likely to remain in treatment and engage in mental health therapy.[3-2] **[Quality]**

For LHCC, the following opportunities for improvement were identified:

- LHCC's performance for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures ranked below the NCQA national 50th percentile benchmark for all indicators, with both the *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators falling below the SWA. The importance of providing follow-up care for these measures is critical to improving patient outcomes and decreasing the likelihood of re-hospitalization,[3-3] ensuring fewer repeat emergency department (ED) visits, improved physical and mental function, and increased compliance with follow-up instructions,[3-4] as well as a reduction in substance use, future ED use, hospital admissions and bed days,[3-5] respectively. **[Quality, Timeliness, and Access]**
- LHCC's performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure ranked below the NCQA national 50th percentile benchmark. Lack of appropriate care for diabetes for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream.[3-6] **[Quality]**
- LHCC's performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure ranked below the NCQA national 50th percentile benchmark and SWA. Antipsychotic prescribing for children and adolescents has increased rapidly in recent decades. These medications can elevate a child's risk for developing serious metabolic health complications. Given these risks and the potential lifelong consequences, metabolic monitoring (blood glucose and cholesterol

3-2 National Committee for Quality Assurance. Pharmacotherapy for Opioid Use Disorder (POD). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-for-opioid-use-disorder/. Accessed on: Dec 18, 2023.
3-3 National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Dec 18, 2023.
3-4 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Dec 18, 2023.
3-5 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/. Accessed on: Dec 18, 2023.
3-6 National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD, SMD, SMC). Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Jan 10, 2024.

testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[3-7] **[Quality]**

- LHCC's performance for the *Lead Screening in Children* measure ranked below the NCQA national 50th percentile benchmark and SWA. If not found early, exposure to lead and high blood lead levels can lead to irrevocable effects on a child's physical and mental health. Because children who are exposed to lead often have no obvious symptoms, lead poisoning often goes unrecognized. Screening for lead is an easy way to detect an abnormal blood lead level in children.[3-8] **[Quality]**
- LHCC's performance for the *Flu Vaccinations for Adults Ages 18 to 64* measure ranked below the NCQA national 50th percentile benchmark and SWA. Influenza is a common and contagious respiratory illness caused by a set of viruses that can result in serious complications or death. The best protection against flu is to get the annual flu vaccine.[3-9] **[Quality]**
- LHCC's performance for all *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators ranked below the NCQA national 50th percentile benchmark and SWA. Health lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases. Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.[3-10] **[Quality]**
- LHCC's performance for all *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators ranked below the NCQA national 50th percentile benchmark and SWA. Quitting smoking and tobacco use can save lives and improve overall health. Comprehensive cessation interventions that motivate and help users to quit tobacco use can be very effective. Healthcare providers also play an important role in supporting tobacco users and their efforts to quit.[3-11] **[Quality]**
- LHCC's performance for the *Controlling High Blood Pressure* and *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measures ranked below the NCQA national 50th percentile benchmark and SWA. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions. Healthcare providers and plans can help individuals manage their high blood pressure by

3-7 National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Jan 30, 2024.

3-8 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Dec 18, 2023.

3-9 National Committee for Quality Assurance. Flu Vaccinations (FVA, FVO). Available at: https://www.ncqa.org/hedis/measures/flu-vaccinations/. Accessed on: Dec 18, 2023.

3-10 National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). Available at: https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/. Accessed on: Jan 30, 2024.

3-11 National Committee for Quality Assurance. Medical Assistance With Smoking and Tobacco Use Cessation (MSC). Available at: https://www.ncqa.org/hedis/measures/medical-assistance-with-smoking-and-tobacco-use-cessation/. Accessed on: Jan 30, 2024.

prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.[3-12] **[Quality]**

- LHCC's performance for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure ranked below the NCQA national 50th percentile benchmark and SWA. Although antipsychotic medications may serve as effective treatment for a narrowly defined set of psychiatric disorders in children and adolescents, they are often prescribed for nonpsychotic conditions for which psychosocial interventions are considered first-line treatment. Safer, first-line psychosocial interventions may be underutilized, and children and adolescents may unnecessarily incur the risks associated with antipsychotic medications.[3-13] **[Quality]**
- LHCC's performance for the *Non-Recommended Cervical Screening in Adolescent Females* measure ranked below the NCQA national 50th percentile benchmark and SWA. Cervical cancer screening can result in more harm than benefits for adolescent females. Adolescent females tend to have high rates of transient HPV infection and regressive cervical abnormalities. This may produce false-positive results and lead to unnecessary and potentially detrimental follow-up tests and treatment.[3-14] **[Quality]**
- LHCC's performance for both *Prenatal and Postpartum Care* measure indicators ranked below the NCQA national 50th percentile benchmark and SWA. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[3-15] **[Quality, Timeliness, and Access]**

For LHCC, the following recommendations were identified:

- HSAG recommends that LHCC focus its efforts on increasing timely follow-up care for members following discharge. LHCC should also consider conducting a root cause analysis for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures and implementing appropriate interventions to improve performance, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**
- HSAG recommends that LHCC focus its efforts on increasing low-density lipoprotein cholesterol and HbA1c testing among members with diabetes and schizophrenia. LHCC should consider conducting a root cause analysis for the *Diabetes Monitoring for People With Diabetes and*

[3-12] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 10, 2024.
[3-13] National Committee for Quality Assurance. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). Available at: https://www.ncqa.org/hedis/measures/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-anti-psychotics/. Accessed on: Jan 24, 2024.
[3-14] National Committee for Quality Assurance. Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS). Available at: https://www.ncqa.org/hedis/measures/non-recommended-cervical-cancer-screening-in-adolescent-females/. Accessed on: Jan 24, 2024.
[3-15] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 30, 2024.

Schizophrenia measure and implementing appropriate interventions to improve performance, such as patient and provider education. **[Quality]**

- HSAG recommends that LHCC focus its efforts on increasing metabolic testing for children and adolescents with ongoing antipsychotic medication use. LHCC should consider conducting a root cause analysis for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure and implementing appropriate interventions to improve performance, such as provider education and member incentives. **[Quality]**
- HSAG recommends that LHCC focus its efforts on increasing lead capillary or venous blood tests for children prior to their second birthday. LHCC should also consider conducting a root cause analysis for the *Lead Screening in Children* measure and implementing appropriate interventions to improve performance, such as incorporating lead blood tests into well-child examinations when possible. **[Quality]**
- HSAG recommends that LHCC focus its efforts on increasing flu vaccinations for adults. LHCC should also consider conducting a root cause analysis for the *Flu Vaccinations for Adults Ages 18 to 64* measure and implementing appropriate interventions to improve performance, such as outreach campaigns, vaccination reminders, and expanding upon locations to access vaccinations. **[Quality]**
- HSAG recommends that LHCC focus its efforts on incorporating discussion of BMI, nutrition, and physical activity into each outpatient visit for children/adolescents whenever possible. LHCC should also consider conducting a root cause analysis for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure and implementing appropriate interventions to improve performance, such as outreach campaigns, member incentives, and patient and provider education. **[Quality]**
- HSAG recommends that LHCC focus its efforts on increased interventions and medical assistance with smoking and tobacco use cessation for members. LHCC should also consider conducting a root cause analysis for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure and implementing appropriate interventions to improve performance, such as patient education and member incentives. **[Quality]**
- HSAG recommends that LHCC focus its efforts on improving upon blood pressure management for members diagnosed with hypertension. LHCC should also consider conducting a root cause analysis for the *Controlling High Blood Pressure* measure and implementing appropriate interventions to improve performance, such as patient and provider education, and outreach campaigns. **[Quality]**
- HSAG recommends that LHCC focus its efforts on improving and supporting adequate control of blood pressure for patients with diabetes. LHCC should also consider conducting a root cause analysis for the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure and implementing appropriate interventions to improve performance, such as patient education and member incentives. **[Quality]**
- HSAG recommends that LHCC focus its efforts on improving upon treatment for children and adolescents through the appropriate use of first-line psychosocial interventions. LHCC should consider conducting a root cause analysis for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure and implementing appropriate interventions to improve performance, such as provider education. **[Quality]**

- HSAG recommends that LHCC focus its efforts on decreasing unnecessary screenings for cervical cancer among adolescent females. LHCC should also consider conducting a root cause analysis for the *Non-Recommended Cervical Screening in Adolescent Females* measure and implementing appropriate interventions to improve performance, such as provider education. **[Quality]**
- HSAG recommends that LHCC focus its efforts on increasing timely prenatal and postpartum care for members. LHCC should also consider conducting a root cause analysis for the *Prenatal and Postpartum Care* measure and implementing appropriate interventions to improve performance, such as outreach campaigns, patient and provider education, and member incentives. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

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

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

Technical Methods of Data Collection

CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[3-16] specifies that, in lieu of conducting a full on-site Information Systems Capabilities Assessment (ISCA), the EQRO may review an assessment of the MCO's IS conducted by another party. If an MCO is accredited by NCQA, the MCO will have received a full IS assessment as part of its annual HEDIS Compliance Audit by an NCQA HEDIS Compliance Audit licensed organization (LO). In this case, HSAG would request and review the MCO's NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap), FAR, and the data submission tool in lieu of conducting an on-site assessment.

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

HEDIS Measure Validation

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

[3-16] 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.

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

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

Non-HEDIS Measure Validation

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

In accordance with the MY 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 MY 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 3-6. The measures marked *NA* are related to utilization of services.

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

Performance Measure	Quality	Timeliness	Access
Childhood Immunization Status—DTaP, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Pneumococcal Conjugate, Hepatitis A*, *Rotavirus*, *Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*	✓		✓
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*	✓		✓

Performance Measure	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Ambulatory Care—Outpatient Visits/1,000 MM and *Emergency Department Visits/1,000 MM*	NA	NA	NA
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*	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓	n/a	n/a
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
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. LDH plans to use CY 2024 for remediation and to prepare for a new CR cycle. Table 4-1 presents an overview of the results for LHCC.

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

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

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

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

During the 2023 CR, LHCC received a compliance score of 85.7 percent for Standard I—Enrollment and Disenrollment, which identified LHCC has opportunities for improvement. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed. For any elements HSAG scored *Not Met*, LHCC is required to submit a CAP to bring the element into compliance with the applicable standard(s).

Follow-Up on Previous Compliance Review Findings

LDH contracted HSAG to assess the remediation LHCC conducted as a result of the deficiencies identified in the prior year's CR (conducted by LDH's previous EQRO). LHCC was issued a CAP and required to remediate each element as recommended by the previous EQRO. During this year's virtual partial compliance audit, HSAG reviewed the recommendations made by the previous EQRO and LHCC's response. LHCC submitted additional documentation or implemented policies and procedures to meet requirements. LHCC also completed a response document to describe its remediation efforts for each element. HSAG then assessed all remediation elements to determine if compliance with requirements had been met and assigned a final score. Table 4-2 presents an overview of the results for LHCC.

Table 4-2—Summary of Scores for the CAP From the CY 2021 Review

N/A	Total Elements in CAP	Number of Elements		Total Compliance Score From CAP
		M	*NM*	
Follow-Up on CAPs From Prior CR	24	22	2	91.7%

M=*Met*, ***NM***=*Not Met*
Total Elements in CAP: The total number of elements within the CAP from the CY 2021 review. This represents the denominator.
Total Compliance Score From CAP: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

LHCC achieved compliance in 22 of 24 elements from the LDH-approved 2022 CR CAPs. LHCC must implement the remaining approved CAPs for the two elements for which compliance was not achieved.

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- LHCC's policies and procedures ensured that LHCC did not inappropriately request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, or diminished mental capacity. **[Quality and Access]**
- LHCC implemented documented processes that focus on ensuring members are not disenrolled for any reason other than those stated in the LDH contract. **[Quality and Access]**

For LHCC, the following opportunity for improvement was identified:

- LHCC's policies and procedures failed to include all requirements in Standard I—Enrollment and Disenrollment. **[Quality and Access]**

For LHCC, the following required action and recommendation were identified:

- LHCC must revise its policies and procedures to include all requirements in Standard I—Enrollment and Disenrollment as detailed in the CR report. **[Quality and Access]**

Methodology

Standards

Table 4-3 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 4-3—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 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 4-4 describes the standards and associated regulations and requirements reviewed for each standard.

Table 4-4—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 4-5 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 4-5—Protocol Activities Performed for Assessment of Compliance With Regulations

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

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and 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 4-6 depicts assignment of the standards to the domains of care.

Table 4-6—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 LHCC 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 LHCC by specialty type.

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

Specialty Type	Sampled Cases	Respondents	Refusals*	Bad Phone Number**	Unable to Reach***	Response Rate
Total	**125**	**114**	**0**	**5**	**6**	**91.2%**
Internal Medicine/Family Medicine	25	23	0	0	2	92.0%
Pediatrics	25	25	0	0	0	100%
Obstetrics/Gynecology (OB/GYN)	25	22	0	3	0	88.0%
Specialists (any)	25	25	0	0	0	100%
Behavioral Health (any)	25	19	0	2	4	76.0%

* 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 LHCC by specialty type.

Table 5-2—Indicator Match Rates for LHCC 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	**100**	**87.7%**	**100**	**87.7%**	**91**	**79.8%**	**87**	**76.3%**	**78**	**68.4%**	**99**	**86.8%**
Internal Medicine/Family Medicine	21	91.3%	20	87.0%	18	78.3%	17	73.9%	15	65.2%	20	87.0%
Pediatrics	25	100%	23	92.0%	20	80.0%	22	88.0%	22	88.0%	22	88.0%
OB/GYN	16	72.7%	18	81.0%	16	72.7%	16	72.7%	12	54.5%	18	81.8%
Specialists (any)	23	92.0%	23	92.0%	23	92.0%	19	76.0%	17	68.0%	23	92.0%
Behavioral Health (any)	15	78.9%	16	84.2%	14	73.7%	13	68.4%	12	63.2%	16	84.2%

Table 5-3 presents LHCC'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**	**65**	**59.5%**
Internal Medicine/Family Medicine	25	14	61.3%
Pediatrics	25	20	85.3%
OB/GYN	25	9	49.3%
Specialists (any)	25	15	64.0%
Behavioral Health (any)	25	7	37.3%

[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.
[2] The compliance scores shaded in green indicate the compliance score met the ≥ 75 percent requirement.

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

Table 5-4—Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**60**	**48.0%**
Total reasons for noncompliance	**65**	**Not Applicable**
Provider does not participate with MCO or Louisiana Medicaid	22	17.6%
Provider is not at site	8	6.4%
Provider not accepting new patients	1	0.8%
Wrong telephone number	0	0.0%
No response/busy signal/disconnected telephone number (after three calls)	11	8.8%
Representative does not know	0	0.0%
Incorrect address reported	10	8.0%
Address (suite number) needs to be updated	4	3.2%
Wrong specialty reported	9	7.2%

GeoAccess Provider Network Accessibility

LHCC's contract with LDH (effective dates January 1, 2023–December 31, 2025) requires LHCC 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 LHCC 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 LHCC's contract with LDH.

Table 5-5—GeoAccess Results for LHCC—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%	99.8%	99.6%
	Rural	30 miles/100%	100%	100%
Pediatric Primary Care	Urban	10 miles/100%	99.7%	99.6%
	Rural	30 miles/100%	100%	100%
FQHCs	Urban	10 miles/100%	89.9%	NR*
	Rural	30 miles/100%	63.5%	NR*
RHCs	Urban	10 miles/100%	46.2%	NR*
	Rural	30 miles/100%	85.2%	NR*
Acute Inpatient Hospitals	Urban	10 miles/100%	85.9%	83.1%
	Rural	30 miles/100%	99.9%	99.8%
Ancillary Care—Laboratory	Urban	20 miles/100%	99.9%	99.8%
	Rural	30 miles/100%	99.9%	99.8%
Ancillary Care—Radiology	Urban	20 miles/100%	99.6%	99.5%
	Rural	30 miles/100%	99.9%	99.8%
Ancillary Care—Pharmacy	Urban	10 miles/100%	97.7%	97.6%
	Rural	30 miles/100%	100%	100%
Ancillary Care—Hemodialysis	Urban	10 miles/100%	99.7%	99.5%
	Rural	30 miles/100%	99.9%	99.9%
Specialty Care—OB/GYN	Urban	15 miles/100%	95.6%	95.7%
	Rural	30 miles/100%	93.9%	91.7%
Allergy/Immunology	Urban or Rural	60 miles/100%	99.4%	98.3%
Cardiology	Urban or Rural	60 miles/100%	99.9%	99.9%

Provider Type	Region	Standard	Reporting Period 07/01/22—12/31/22	Reporting Period 01/01/23—06/30/23
Dermatology	Urban or Rural	60 miles/100%	96.3%	83.5%
Endocrinology and Metabolism	Urban or Rural	60 miles/100%	93.7%	97.3%
Gastroenterology	Urban or Rural	60 miles/100%	99.9%	99.9%
Hematology/Oncology	Urban or Rural	60 miles/100%	99.6%	99.6%
Nephrology	Urban or Rural	60 miles/100%	99.9%	99.9%
Neurology	Urban or Rural	60 miles/100%	99.9%	99.6%
Ophthalmology	Urban or Rural	60 miles/100%	99.9%	99.2%
Orthopedics	Urban or Rural	60 miles/100%	99.9%	99.9%
Otorhinolaryngology/ Otolaryngology	Urban or Rural	60 miles/100%	99.9%	99.9%
Urology	Urban or Rural	60 miles/100%	99.8%	99.9%

Meets the required distance standards
Results of 99.0% or higher

NR—Not Reported; LHCC did not report GeoAccess mapping for the specified service type during this quarter.
NR*—LHCC did not provide compliance with distance standards for FQHCs or RHCs during this reporting period.

Table 5-6 presents the percentage of members LHCC 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 LHCC's contract with LDH.

Table 5-6—GeoAccess Results for LHCC—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—03/01/23	Quarter 4 04/01/23—06/30/23
Specialty Care—Psychiatrists	Urban	15 miles/100%	96.3%	96.6%	96.6%	96.9%
	Rural	30 miles/100%	99.8%	99.9%	99.3%	99.5%
Behavioral Health Specialists	Urban	15 miles/100%	98.2%	98.4%	99.0%	99.0%
	Rural	30 miles/100%	99.9%	99.9%	99.9%	99.9%
All Prescribers	Urban	15 miles/100%	98.5%	98.5%	NR*	NR*
	Rural	30 miles/100%	99.9%	99.9%	NR*	NR*
Pediatric PRTF	Urban or Rural	200 miles/100%	99.9%	99.9%	100%	100%
ASAM LOC 1	Urban	15 miles/100%	NR	NR	91.1%	92.2%
	Rural	30 miles/100%	NR	NR	97.2%	97.2%
ASAM LOC 2.1	Urban	15 miles/100%	NR	NR	92.2%	92.2%
	Rural	30 miles/100%	NR	NR	94.0%	94.2%
ASAM LOC 2WM	Urban	60 miles/100%	NR	NR	73.0%	73.0%
	Rural	60 miles/100%	NR	NR	75.5%	75.5%
ASAM LOC 3.1 Adult	Urban	30 miles/100%	NR	NR	95.3%	95.3%
	Rural	30 miles/100%	NR	NR	50.6%	50.7%
ASAM LOC 3.1 Pediatric/Adolescent	Urban or Rural	60 miles/100%	NR	NR	98.5%	98.5%
ASAM LOC 3.2WM Adult	Urban	60 miles/100%	NR	NR	92.1%	92.1%
	Rural	60 miles/100%	NR	NR	77.1%	77.0%
ASAM LOC 3.2WM Pediatric/Adolescent	Urban or Rural	60 miles/100%	NR	NR	87.5%	87.5%
ASAM LOC 3.3 Adult	Urban	30 miles/100%	89.2%	88.5%	88.5%	88.4%
	Rural	30 miles/100%	64.6%	64.3%	64.2%	64.4%

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—03/01/23	Quarter 4 04/01/23—06/30/23
ASAM LOC 3.5 Adult	Urban	30 miles/100%	94.9%	95.1%	95.1%	95.1%
	Rural	30 miles/100%	73.5%	73.5%	73.4%	73.5%
ASAM LOC 3.7 Adult	Urban	60 miles/100%	98.4%	98.2%	89.1%	90.9%
	Rural	60 miles/100%	91.3%	91.7%	84.8%	95.3%
ASAM LOC 3.7WM Adult	Urban	60 miles/100%	99.9%	99.9%	99.9%	99.9%
	Rural	60 miles/100%	97.8%	97.9%	97.9%	97.8%
ASAM LOC 3.5 Pediatric	Urban or Rural	60 miles/100%	99.5%	99.5%	99.3%	99.4%
Inpatient Psychiatric	Urban	90 miles/100%	99.9%	99.9%	99.9%	100%
	Rural	90 miles/100%	100%	100%	100%	100%
Medication-Assisted Treatment (MAT)	Urban	15 miles/100%	95.3%	95.8%	95.8%	96.0%
	Rural	30 miles/100%	97.7%	97.8%	97.8%	97.8%
Behavioral Health Rehabilitation	Urban	15 miles/100%	NR	NR	94.5%	94.5%
	Rural	30 miles/100%	NR	NR	98.8%	98.8%

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.
NR*—LHCC did not provide compliance with distance standards for FQHCs or RHCs during this reporting period.

LHCC submitted network plans for SFY 2022–2023 to address gaps in provider accessibility. LHCC reported that in some rural parishes where network gaps continue to exist, LHCC has contracted with all available providers. To address the gaps in sufficiency of the network providing ASAM LOCs, LHCC reported conducting conference calls with network provider organizations to encourage providers to expand the LOCs provided and offer enhanced reimbursement rates for adding service locations. LHCC reported that one provider planned to open two additional locations during SFY 2022–2023.

LHCC reported that one provider relocated a facility, which caused an increase in the network gap for ASAM LOC 3.7. LHCC reported continuing to target providers for recruitment where network gaps exist.

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- The overall PDV response rate was 91.2 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]**
- In the PDV, LHCC had a match rate of 100 percent for the address indicator (i.e., accuracy of LHCC's directory reflecting the correct address) for pediatric providers. Additionally, internal medicine/family medicine and specialists had a match rate above 90 percent for the address indicator. Correct address information is essential for members to locate providers when seeking care. **[Quality and Access]**
- Pediatrics and specialists had a PDV match rate above 90 percent for the provider affiliation indicator. Correct provider information is essential for members to locate providers when seeking care. **[Quality and Access]**
- Overall, 92.0 percent of specialist provider locations confirmed the provider directory reflected the provider's correct specialty. Correct provider information is essential for members to locate providers when seeking care. **[Quality and Access]**
- LHCC met the PDV ≥ 75 percent compliance score requirement for pediatrics with a compliance score of 85.3 percent. Exceeding the LDH compliance score indicates LHCC's pediatrics information is accurate and has a positive impact on a member's experience seeking pediatric care. **[Quality and Access]**
- For GeoAccess, LHCC achieved above 99 percent on nine of 12 physical health provider types reported for the urban and rural populations together. **[Access]**
- LHCC members had adequate access to primary care, as both urban and rural areas achieved GeoAccess results over 99 percent for adult and pediatric primary care. **[Access]**
- For all four quarters, LHCC achieved GeoAccess results above 99 percent for rural specialty care psychiatrists, urban pediatric PRTF, urban ASAM LOC 3.7WM adults, urban and rural ASAM LOC 3.5 pediatric, and urban and rural inpatient psychiatric providers. **[Quality and Access]**

For LHCC, the following opportunities for improvement were identified:

- Acceptance of Louisiana Medicaid had an overall match rate at 68.4 percent across all provider types in the PDV. **[Quality and Access]**
- Acceptance of the MCO had an overall match rate at 76.3 percent across all provider types in the PDV. **[Quality and Access]**
- Overall, 79.8 percent of providers confirmed the specialty listed in the online provider directory was accurate. **[Quality and Access]**
- Overall, 86.8 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]**

- In the PDV, 87.7 percent of the locations confirmed affiliation with the sampled provider. **[Quality and Access]**
- 87.7 percent of PDV respondents confirmed LHCC's directory reflected the correct address. **[Quality and Access]**
- LHCC demonstrated a shortage of FQHCs and RHCs, with urban and rural GeoAccess results below 90 percent for the first reporting period and not reported for the second reporting period. **[Access]**
- LHCC did not meet any GeoAccess standards for any ASAM provider types. **[Quality and Access]**

For LHCC, the following recommendations were identified:

- LDH should provide LHCC 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, LHCC 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]**
- LHCC should determine if there are FQHCs and RHCs available for contracting and, if available, pursue contracting efforts to meet GeoAccess standards. **[Access]**
- LHCC should conduct an in-depth review of ASAM provider types as 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 LHCC has requested exemptions from LDH for provider types for which providers may not be available or willing to contract. **[Quality and Access]**
- LHCC 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	✓		✓

Results

Table 6-1 presents LHCC's 2022 and 2023 adult achievement scores.

Table 6-1—Adult Achievement Scores for LHCC

Measure	2022	2023
Rating of Health Plan	77.94%	77.08%
Rating of All Health Care	NA	71.43%
Rating of Personal Doctor	84.07%	83.25%
Rating of Specialist Seen Most Often	NA	NA
Getting Needed Care	NA	75.06%
Getting Care Quickly	NA	85.07%
How Well Doctors Communicate	NA	92.80%
Customer Service	NA	NA

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

↑ *Indicates the 2023 score is statistically significantly higher than the 2023 NCQA national average.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the 2023 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2023 score is statistically significantly lower than the 2022 score.*

Table 6-2 presents LHCC's 2022 and 2023 general child achievement scores.

Table 6-2—General Child Achievement Scores for LHCC

Measure	2022	2023
Rating of Health Plan	86.78%	86.26%
Rating of All Health Care	NA	87.69%
Rating of Personal Doctor	87.39%	89.38%
Rating of Specialist Seen Most Often	NA	NA
Getting Needed Care	NA	NA
Getting Care Quickly	NA	NA
How Well Doctors Communicate	NA	95.21%
Customer Service	NA	NA

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

↑ *Indicates the 2023 score is statistically significantly higher than the 2023 NCQA national average.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the 2023 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2023 score is statistically significantly lower than the 2022 score.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- For the adult and general child population, LHCC's scores were not statistically significantly higher in 2023 than 2022 nor statistically significantly higher than the 2023 NCQA national average on any measure; therefore, no strengths were identified.

For LHCC, the following opportunities for improvement were identified:

- For the adult and general child populations, LHCC's 2023 achievement scores were not statistically significantly lower than in 2022, and scores were not statistically significantly lower than the 2023 NCQA national average on any measure; therefore, no opportunities for improvement were identified.

For LHCC, the following recommendation was identified:

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

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

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

[6-1] For this report, the 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.

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.

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 (▼)

[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.

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 6-3.

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

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

[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

Table 7-1 presents the adult 2023 achievement scores for LHCC and the Healthy Louisiana SWA.

Table 7-1—Adult Achievement Scores for LHCC

Measure	2023	Healthy Louisiana SWA
Rating of Health Plan	55.65%	58.96%
How Well People Communicate	91.35%	90.06%
Cultural Competency	66.67%+	73.77%+
Helped by Counseling or Treatment	68.55%	67.65%
Treatment or Counseling Convenience	86.29%	86.70%
Getting Needed Treatment	81.97%	77.08%
Help Finding Counseling or Treatment	37.50%+	47.04%
Customer Service	64.29%+	67.14%+
Helped by Crisis Response Services	85.71%+	76.09%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
↑ *Indicates the 2023 score is statistically significantly higher than the 2023 Healthy Louisiana SWA.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 Healthy Louisiana SWA.*

Table 7-2 presents the child 2023 achievement scores for LHCC and the Healthy Louisiana SWA.

Table 7-2—Child Achievement Scores for LHCC

Measure	2023	Healthy Louisiana SWA
Rating of Health Plan	70.37%+	62.67%
How Well People Communicate	96.29%+	92.54%
Cultural Competency	100%+	97.85%+
Helped by Counseling or Treatment	68.52%+	58.20%
Treatment or Counseling Convenience	92.45%+	89.52%
Getting Needed Treatment	84.91%+	77.36%
Help Finding Counseling or Treatment	66.67%+	41.85%+
Customer Service	60.00%+	61.54%+
Getting Professional Help	90.57%+	88.83%
Help to Manage Condition	94.23%+	85.94%

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- For the adult and child populations, LHCC did not score statistically significantly higher than the 2023 Healthy Louisiana SWA on any measure; therefore, no strengths were identified.

For LHCC, the following opportunities for improvement were identified:

- For the adult and child populations, LHCC did not score statistically significantly lower than the 2023 Healthy Louisiana SWA on any measure; therefore, no opportunities for improvement were identified.

For LHCC, the following recommendations were identified:

- HSAG recommends LHCC monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**
- HSAG recommends LHCC focus on increasing response rates to the behavioral health member satisfaction survey for both populations so there are greater than 100 respondents for each measure. This can be achieved by educating and engaging all employees to increase their knowledge of surveys and providing awareness to members during the survey period. Additionally, member-facing teams, such as the customer service team, could consider asking members if they know about the behavioral health member satisfaction survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to LHCC. The information provided by these members could be shared with LDH to help identify solutions to address low response rates. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom behavioral health member satisfaction survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from 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 7-3.

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

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
How Well People Communicate	✓		
Cultural Competency	✓		
Helped by Counseling or Treatment	✓		
Treatment or Counseling Convenience			✓
Getting Counseling or Treatment Quickly	✓	✓	
Getting Needed Treatment	✓		✓
Barriers to Counseling or Treatment	✓		✓
Help Finding Counseling or Treatment	✓		✓

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
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.

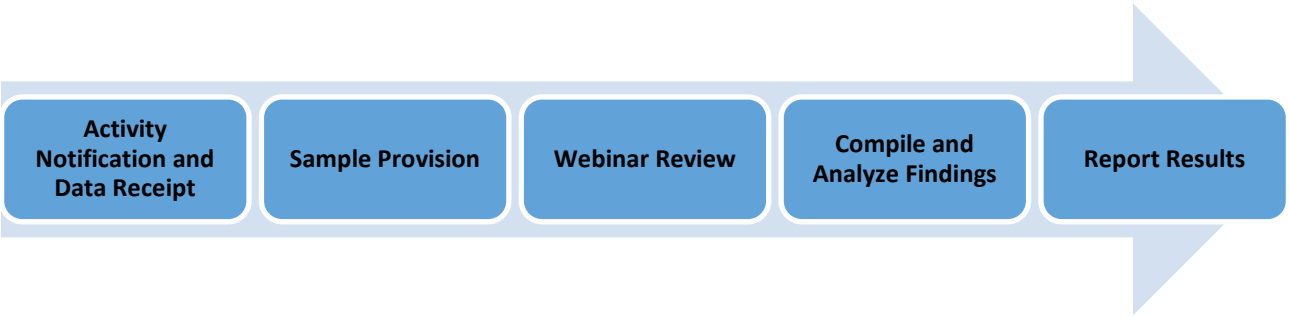
HSAG's CMPE review tool will comprehensively address the services and supports that are necessary to meet enrollees' needs. The tool will include elements for review of CM documentation and enrollee care

[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

The 2023 (CY 2022) QRS results for LHCC are displayed in Table 9-1.

Table 9-1—2023 (CY 2022) QRS Results

Composites and Subcomposites	LHCC
Overall Rating*	**3.0**
Consumer Satisfaction	**3.0**
Getting Care	2.5
Satisfaction with Plan Physicians	3.5
Satisfaction with Plan Services	3.0
Prevention	**2.5**
Children and Adolescent Well-Care	2.0
Women's Reproductive Health	2.5
Cancer Screening	3.5
Other Preventive Services	3.0
Treatment	**2.5**
Respiratory	2.5
Diabetes	2.0
Heart Disease	2.5
Behavioral Health—Care Coordination	1.5
Behavioral Health—Medication Adherence	3.0
Behavioral Health—Access, Monitoring, and Safety	3.0
Risk-Adjusted Utilization	3.0

**This rating includes all measures in the 2023 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*
Insufficient Data indicates that the plan was missing most data for the composite or subcomposite.

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- For the Consumer Satisfaction composite, LHCC received 3.5 points for the Satisfaction with Plan Physicians subcomposite. This subcomposite is based on LHCC member responses to CAHPS survey questions, demonstrating LHCC members are satisfied with their providers. **[Quality]**
- For the Prevention composite, LHCC received 3.5 points for the Cancer Screening subcomposite, demonstrating strength ensuring women receive breast and cervical cancer screenings. **[Quality and Access]**

For LHCC, the following opportunities for improvement were identified:

- For the Prevention composite, LHCC received 2.0 points for the Children and Adolescent Well-Care subcomposite, demonstrating opportunities for improvement for LHCC related to ensuring children 2 years of age receive important immunizations, and ensuring BMI percentiles are documented for children and adolescents. **[Quality and Access]**
- For the Treatment composite, LHCC received 2.0 points for the Diabetes subcomposite, demonstrating opportunities for LHCC to ensure appropriate treatment of diabetes. LHCC also received 1.5 points for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for LHCC to ensure timely follow-up after hospitalizations and ED visits for mental illness. **[Quality, Access, and Timeliness]**

LHCC should reference the recommendations made in Section 3—Validation of Performance Measures and Section 6—Consumer Surveys: CAHPS-A and CAHPS-C as the 2023 Health Plan Report Card reflects HEDIS and CAHPS results.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the five Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. 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]

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

[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.

[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.

- 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 9-2. For the *Plan All-Cause Readmissions* measure, HSAG followed NCQA's methodology for scoring risk-adjusted utilization measures.

Table 9-2—Measure Rate Scoring Descriptions

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

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 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 9-3.

Table 9-3—Scoring Rounding Rules

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

How Conclusions Were Drawn

For the 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 LHCC's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides LHCC's strengths, opportunities for improvement, and recommendations in Table 10-1 through Table 10-3.

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

Overall MCO Strengths	
Quality	• LHCC's rate for the *Chlamydia Screening in Women* measure was at or above the NCQA national 50th percentile benchmark. This suggests women were receiving screenings which are important for improved outcomes and reduction of complications. • LHCC's performance for the *Pharmacotherapy for Opioid Use Disorder* measure ranked above the NCQA national 50th percentile benchmark and SWA. Pharmacotherapy has been identified as a critical part of treatment for individuals with OUD. Encouraging pharmacotherapy is critical because individuals with OUD who engage in treatment with pharmacotherapy are less likely to exhibit withdrawal or craving symptoms and use illicit opioids, and are more likely to remain in treatment and engage in mental health therapy.[10-1] **[Quality]**
Timeliness	• No strengths identified.
Access	• LHCC was the highest performing MCO for GeoAccess standards for physical health and behavioral health provider types in urban areas.

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

Overall MCO Opportunities for Improvement	
Quality, Timeliness, and Access	• LHCC had challenges in following up and managing the care of members that accessed the hospital or ED for mental illness and substance abuse. LHCC's performance for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures ranked below the NCQA national 50th percentile benchmark for all indicators. The *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit for Substance Use* measure rates also fell below the SWA. • LHCC's performance for both *Prenatal and Postpartum Care* measure indicators ranked below the NCQA national 50th percentile benchmark and SWA. **[Quality, Timeliness, and Access]**

[10-1] National Committee for Quality Assurance. Pharmacotherapy for Opioid Use Disorder (POD). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-for-opioid-use-disorder/. Accessed on: Jan 31, 2024.

Overall MCO Opportunities for Improvement	
Quality	• LHCC demonstrated opportunities to improve critical aspects of preventive care for children and adolescents. The *Lead Screening in Children* and measure rate was below the NCQA national 50th percentile benchmark. Rates were also low for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, meaning opportunities were missed to assess the BMI of children and adolescents and provide nutrition and counseling. • LHCC demonstrated weakness with monitoring and appropriate treatment for children on antipsychotic medications. The rates for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measures were below the NCQA national 50th percentile benchmark and SWA. • LHCC's performance for the following measures ranked below the NCQA national 50th percentile benchmark and SWA: – *Flu Vaccinations for Adults Ages 18 to 64* – *Medical Assistance With Smoking and Tobacco Use Cessation* – *Controlling High Blood Pressure* – *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* – *Non-Recommended Cervical Screening in Adolescent Females*
Access	• The results of several EQR activities indicate opportunities for LHCC to improve access to care for its members. LHCC demonstrated a shortage of FQHCs and RHCs, and only 68.4 percent of all provider types in the PDV accepted Louisiana Medicaid.

Table 10-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
LHCC should conduct a root cause analysis for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures and implement appropriate interventions to improve performance, such as providing patient and provider education and enhancing communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.	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
LHCC should convene a focus group to conduct root cause analyses to determine barriers to child and adolescent members accessing preventive care. The focus group should include parent/guardian and provider participation as well as subject matter experts. The focus group should recommend evidenced-	Goal 1: Ensure access to care to meet enrollee needs Goal 4: Promote wellness and prevention Goal 7: Pay for value and incentivize innovation

Overall MCO Recommendations	
based interventions that address barriers. LHCC should consider holistic and novel interventions that aim to increase preventive care rates rather than reiterating previous interventions focused on specific topics or short-term campaigns.	
LHCC should focus its efforts on increasing metabolic testing for children and adolescents with ongoing antipsychotic medication use and on increased use of first-line psychosocial interventions for children and adolescents on antipsychotics. LHCC should consider conducting a root cause analysis for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measures and implementing appropriate interventions to improve performance. **[Quality]**	Goal 1: Ensure access to care to meet enrollee needs Goal 3: Facilitate patient-centered, whole-person care Goal 3: Facilitate patient-centered, whole-person care
LHCC should focus its efforts on increasing timely prenatal and postpartum care for members. LHCC should also consider conducting a root cause analysis for the *Prenatal and Postpartum Care* measure and implementing appropriate interventions to improve performance, such as outreach campaigns, patient and provider education, and member incentives. **[Quality, Timeliness, and Access]**	Goal 1: Ensure access to care to meet enrollee needs Goal 3: Facilitate patient-centered, whole-person care Goal 3: Facilitate patient-centered, whole-person care
To improve access to care, LHCC should adopt a programmatic approach to identify barriers to access across all aspects of Medicaid operations. A planwide taskforce should include provider network staff members, subject matter experts for the access-related HEDIS measures that performed poorly, utilization management staff members, and other members as determined by LHCC. The taskforce should include key community stakeholders to identify barriers/facilitators to members accessing preventive and follow-up care. LHCC should consider multi-tiered approaches such as: • Reviewing provider office procedures for ensuring appointment availability standards. • Conducting "secret shopper" provider office surveys. • Evaluating member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. • Conduct drill-down analyses of access-related measures to determine disparities by race, ethnicity, age group, geographic location, etc.	Goal 1: Ensure access to care to meet enrollee needs Goal 6: Partner with communities to improve population health and address health disparities

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. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2020–2021 recommendations. Table 11-1 through Table 11-7 contain a summary of the follow-up actions that LHCC completed in response to the previous EQRO's SFY 2022 recommendations. Furthermore, HSAG assessed LHCC's approach to addressing the recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

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

High indicates *all* of the following:

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

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

Medium indicates one or more of the following:

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

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

Low indicates one or more the following:

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

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

Table 11-1—Follow-Up on Prior Year's Recommendations for PIPs

1. Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects:
Recommendations
None identified.

Table 11-2—Follow-Up on Prior Year's Recommendations for Performance Measures

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
Recommendations
LHCC should target interventions to improve rates for the measures that fell below the NCQA 50th percentile.
Response
Describe initiatives implemented based on recommendations: LHCC is committed to improving the health of our members as reflected by HEDIS outcomes. Maintaining a cross-functional and collaborative approach, HEDIS performance is monitored regularly through various QAPI subcommittees and workgroup meetings to identify barriers impacting members and providers, with development of interventions to address low performing measures and continually striving to elevate performance across all measures and membership to improve health outcomes. Analysis of low performing measures resulted in identification of opportunities for broad member engagement/PCP visit needs, with additional focus on priority HEDIS areas such as well child visits and immunizations, chronic conditions including diabetes and hypertension, as well as key behavioral measures (although monitoring of all measures is conducted year-round with allocation of resources to target key measures, disparity populations, and outliers identified during the measurement year). HEDIS measures falling below the national 50th percentile were reviewed and interventions implemented, continued, or modified for quality improvement. Interventions include, but are not limited to: • Member outreach/education through multiple modalities, including direct telephonic, automated messaging, texting, social media/online communications, and in-person events to assist with (but not limited to) managing care, making appointments, and scheduling transportation. • Cotiviti (vendor) IVR campaigns for member outreach at scheduled intervals year round, addressing adult & child well visits, condition management and gap closure appointment scheduling, preventive care education

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
& follow up, cancer screenings, and medication adherence reminders for ADHD, antidepressants, and asthma. • Launched targeted outreach campaigns specific to diabetic members with overdue A1c testing, eye exams, and/or past elevated A1c levels warranting follow up. Additional focus on the members in rural areas was done by offering home A1c testing kits that could be returned by mail to encourage engagement and mitigate barriers to compliance. • Provider engagement/education through multiple modalities live and virtual outreach visits, Joint Operating Committees (JOC's), and advisory group meetings. Provider resources were also reviewed and updated to include to address best practice recommendations, coding specifications for key HEDIS metrics, and promotion of available health plan resources to support member engagement and care gap closures. • Provider visits with collaborative meetings across Provider Relations and Quality Teams to review provider scorecards and identify and target members with open gaps. • Provider education on child/adolescent immunizations webinar series offered virtually and recorded for on-demand access. • Review and realignment of member incentives to encourage wellness and prevention visits, with renewed focus on well child, women's and maternal health, and diabetes care. • Continued efforts to expand EHR access and supplemental data sharing connectivity with provider groups for optimal capture of HEDIS gap closure data, reducing administrative burden for providers and allowing for capture of additional documentation of care, treatment and services not reflected in claims submissions. • Analysis of immunization barriers and outliers, identifying vaccine hesitancy and/or knowledge deficits particularly surrounding HPV and flu vaccines, noting that these lower compliance immunizations are impacting overall combo measures. • Focused efforts to improve diabetes care: – Continued member and provider incentives for completion of recommended diabetes testing. – Mail distribution of home A1c testing kits to focused diabetic member populations (i.e., high risk, rural areas, lack of PCP visits). – Provider education offerings expanded to include webinar series on "Improving Outcomes in Patients with Diabetes". • Focused efforts to improve well child/adolescent visits and immunizations: – Included W30 and WCV measures in provider incentive program. – Data exchange through LINKS state immunization registry to identify and retrieve additional immunization encounters/documentation not captured in claims data. • Provider education offerings expanded with webinar series on child/adolescent wellness, including immunizations and COVID-19 vaccinations and considerations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Although thresholds for NCQA 50th percentile were not met for all low performing measures, improvements in year over year HEDIS rates were achieved in 34 measures, with notable increases observed in childhood immunizations, diabetes care, follow up after emergency room visits for mental health and substance use, weight assessment and counseling, antibiotic stewardship, and prenatal/postpartum care measures. Examples of improvements in select HEDIS focus areas since previous ATR feedback included the following: • Well Child Visits & Immunizations – W30 (First 15 months) demonstrated a 4.92% improvement over prior year. – W30 (First 15-30 months) demonstrated a 1.83% improvement over prior year. – WCV (total) demonstrated a 0.56% improvement over prior year.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
– CIS Combo 3 demonstrated a 2.43% improvement over prior year. – WCC Counseling for Nutrition demonstrated a 2.19% improvement over prior year. – WCC Counseling for Physical Activity demonstrated a 3.89% improvement over prior year. • Diabetes Care – A1C poor control (HBD) demonstrated a 6.81% improvement over prior year. – Retinal Eye Exams (EED) exceeded national 50th percentile. – HbA1c control (<8.0%) demonstrated a 3.89% improvement over prior year. – BP control (<140/90 mm Hg) demonstrated a 8.27% improvement over prior year. • Hypertension – Controlling BP (CBP) demonstrated a 6.08% improvement over prior year. • Improvement noted in BH measures for follow-up after emergency department visits for mental illness and alcohol/other drug abuse: – FUA (7d) demonstrated a 7.82% improvement over prior year. – FUA (30d) demonstrated a 14.00% improvement over prior year. – FUM (7d) demonstrated a 1.19% improvement over prior year. • FUM (30d) demonstrated a 1.47% improvement over prior year.
Identify any barriers to implementing initiatives: The ongoing COVID-19 PHE was noted as a continued barrier to improving performance; additionally, barriers to implementation and impact of interventions included challenges with successful member engagement/outreach to promote education, support engagement/compliance with health care appointments and follow up care. Provider documentation/ coding practices and reported staffing resources related to the ongoing public health emergency were noted as a continued area of opportunity and barrier to improvement in some areas.
Identify strategy for continued improvement or overcoming identified barriers: HEDIS improvement is a priority focus for LHCC across all levels of the organization; strategic initiatives and priorities to improve rates include, but are not limited, to the following: • Expanding member outreach education and engagement via digital modalities as an alternative to telephonic outreach for members with limited successful connectivity.; • Updating provider incentive program for optimal collaboration and capture of HEDIS gap closures. • Continued efforts towards EHR integration with large provider groups and most prevalent EHR platforms (i.e., Athena, Epic). • Targeted outreach to identified disparity populations for identified priority measures. • Review and renegotiation of vendor contracts for optimal member support and functionality to drive outcomes (i.e., pursue enhanced digital strategies for improved member engagement/connectivity). • Provider partnerships for collaborative approaches to impact health outcomes and gap closure needs in identified populations and geographic areas.
HSAG Assessment


Table 11-3—Follow-Up on Prior Year's Recommendations for Compliance With Medicaid Managed Care Regulations

3. Prior Year Recommendations from the EQR Technical Report for Compliance With Medicaid Managed Care Regulations:
As described in Section 4—Assessment of Compliance With Medicaid Managed Care Regulations, LDH contracted with HSAG to validate LHCC's remediation of the deficiencies identified in the prior year's CR CAP. HSAG reviewed LHCC's responses and the additional documentation they submitted to assess whether compliance had been reached. The details of this follow-up are included in Appendix B.

Table 11-4—Follow-Up on Prior Year's Recommendations for Network Adequacy

4. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
Recommendations
None identified.

Table 11-5—Follow-Up on Prior Year's Recommendations for CAHPS

5. Prior Year Recommendations from the EQR Technical Report for Validation of Quality of Care Surveys – CAHPS Member Experience Survey:
Recommendations
None identified.

Table 11-6—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey

6. Prior Year Recommendations from the EQR Technical Report for the Behavioral Health Member Satisfaction Survey:
Recommendations
None identified.

Table 11-7—Follow-Up on Prior Year's Recommendations for the Quality Rating System

7. Prior Year Recommendations from the EQR Technical Report for MCO Quality Ratings:
Recommendations
LHCC should concentrate on improving the areas that scored low.
Response
Describe initiatives implemented based on recommendations: LHCC observed rate increases in several HEDIS measures as noted in the preceding section response on noted improvement in Performance Measures. LHCC focused on low performing HEDIS domains was expanded during the year, with increased review and reporting of priority measure progress during HEDIS steering

7. Prior Year Recommendations from the EQR Technical Report for MCO Quality Ratings:
committee meetings, as well as 'deep dive' reviews into selected low performing areas. In addition to the significant emphasis on improving HEDIS rates in the Prevention and Treatment Domains (as described in the section above), emphasis was also placed on analysis and interventions surrounding member experience and CAHPS survey outcomes, including measures that were noted as 'I', representing insufficient data'. Lower than typical response rates in the annual CAHPS surveys, resulted in several CAHPS elements scoring 'not reportable' due to a low denominator. The declines in overall HEDIS measures, combined with low CAHPS survey returns, adversely impacted the overall health plan ratings. Interventions were established to target response rate deficits and facilitate capture of member experience feedback to enable more targeted activities to address areas of opportunity that impact our membership, including oversampling and proactive member communications to promote member engagement and survey awareness.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): As noted under the Performance Improvement responses above, targeted efforts to improve measures under the Treatment Domains included initiatives relative to chronic condition management, such as: • Diabetes Care – A1C poor control (HBD) demonstrated a 6.81% improvement over prior year. – Retinal Eye Exams (EED) exceeded national 50th percentile. – HbA1c control (<8.0%) demonstrated a 3.89% improvement over prior year. – BP control (<140/90 mm Hg) demonstrated a 8.27% improvement over prior year. • Respiratory – Appropriate Treatment for Children with Upper Respiratory Infection (URI) demonstrated a 2.83% improvement over prior year. – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) demonstrated a 10.94% improvement over prior year. • Women's Reproductive Health – Prenatal Care demonstrated a 3.16% improvement over prior year. – Postpartum Care demonstrated a 5.59% improvement over prior year. – Cesarean Rate for Low-Risk First Birth Women demonstrated a 0.10% improvement over prior year. • Consumer Satisfaction – Increase in CAHPS survey return rates to include: o Adult Response rate increased 2.1% over prior year. o Child w/ CCC Response rate increased 3.0% over prior year. – CAHPS Getting Needed Care Quickly (not reportable due to low sample size), demonstrated a 4.69% improvement over prior year
Identify any barriers to implementing initiatives: The ongoing COVID-19 PHE was noted as a continued barrier to improving performance; additionally, barriers to implementation and impact of interventions included challenges with successful member engagement/outreach to promote education, solicit member feedback/responses related to member experience/consumer satisfaction, and generally support engagement/compliance with health care appointments and follow up care. Provider documentation/ coding practices and reported staffing resources related to the ongoing public health emergency were noted as a continued area of opportunity and barrier to improvement in some areas.
Identify strategy for continued improvement or overcoming identified barriers: HEDIS improvement is a priority focus for LHCC across all levels of the organization; strategic initiatives and priorities to improve rates include, but are not limited, to the following: • Expanding member outreach, education, and engagement via digital modalities as an alternative to telephonic outreach while also incorporating identified disparity populations for targeted measures.

7. Prior Year Recommendations from the EQR Technical Report for MCO Quality Ratings:
• Updating provider incentive program for optimal collaboration and capture of HEDIS gap closures. • Continued efforts towards EHR integration with large provider groups and most prevalent EHR platforms (i.e., Athena, Epic). • Provider partnerships for collaborative approaches to impact health outcomes in identified populations and geographic areas. • Continued member incentives for completing Notification of Pregnancy as well as completion of prenatal/post-partum visits. • Continued promotion and expansion of Smart Start for Baby program to pregnant members to promote health pregnancy outcomes. • CAHPS strategy updated to expand oversampling, as well as outreach methodology to include digital options such as email/IVR and QR codes to encourage member participation in surveys.
HSAG Assessment


Appendix A. MCO Health Equity Plan Summary

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

Health Equity Plan

HSAG reviewed LHCC's HEP submitted February 2023. 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 LHCC's Request for Proposal (RFP) responses into a standard set of topics as follows:

Stated Goals

LHCC reported the following programmatic goals in its HEP:

- Transform Louisiana's health, one person at a time.
- Identify social inequities and disparities.
- Promote change.
- Ensure culturally and linguistically sensitive services.
- Invest in the community.
- Address food insecurity.
- Build a culture of equity.

Policies and Procedures

LHCC reported the following organizational policies and procedural program components:

- A deliberate process of learning, aligning, and reimagining what it means to transform health through the lens of health equity and adopting best practices.

- Use LDH's health equity framework and model, which includes listening and embedding the perspectives and voices of the community, analysis of data, best practice identification, restructuring governance, realigning policies and procedures, designing and implement interventions, and evaluating interventions for continuous improvement.
- Use a Population Health Framework as the lever to promote change.
- Lead by example.
- Align with national Culturally and Linguistically Appropriate Services (CLAS) Standards.
- Maintain the NCQA's Multicultural Health Care Distinction status.
- Review every policy and procedure for impact on health equity, underscoring those specific to health equity.
- Include provider languages spoken and language services provided in the provider directory.
- Offer written, verbal, in-person, and on-demand interpretation and translation services for non-English languages including American Sign Language (ASL), for staff interactions and provider appointments.
- Contractually require providers to comply with the Americans with Disabilities Act (ADA) and National CLAS Standards
- Provide psychiatric Intensive Outpatient Program (IOP) as an "in lieu of service."

Staffing and Resources

LHCC reported commitments to the following:

- Creating a purposefully trained and diverse staff and provider network
- Developing a Health Equity and Diversity Committee led by the Vice President (VP) of Health Equity and VP of Population Health and Clinical Operations.
- Deploying Health Equity Action Teams from key functional areas across the organization
- Investing in more than 340 health equity initiatives across Louisiana
- Developing and implementing *Unconscious Bias and Unnatural Causes* training and training to ensure cultural humility and a drive toward health equity
- Offering training via in-person, webinars, and LHCC's e-learning management system to maximize attendance
- Inclusive employment practices to create a diverse workforce reflective of the demographic characteristics of the Medicaid enrollees LHCC serves
- Recruiting, retaining, and promoting employees from different racial and ethnic backgrounds, as well as individuals from the disability, LGBTQ+, and veterans communities.

Leveraging Data

LHCC reported the following:

- Integrated data systems stratify quality performance, utilization metrics, and disease prevalence by race, ethnicity, language, and disability (RELD) data to identify social inequities.
- Use data to inform LHCC's Health Equity Improvement Model.
- Overlay the network data with the enrollee population data to identify and then address provider network gaps.
- Collect and analyze enrollee language data.
- Stratify outcomes data (HEDIS and CAHPS) by race, ethnicity, and language (REL) preference to identify disparities.
- Monitor grievance and appeal data trends related to CLAS, cultural sensitivity, ADA compliance, and RELD.
- Develop memorandums of understanding (MOUs) with community partners for data sharing, to support collaboration.
- Use Z code claims data to provide targeted outreach and to identify and address trends.
- Use utilization data (e.g., for emergency department [ED] visits, hospitalizations, SUD services) to evaluate the effectiveness of the community health worker (CHW) and peer support specialist (PSS) programs.
- Develop a health equity dashboard to display results on specified measures related to health equity and disparities.
- Use LHCC's Neighborhood, Economic, and Social Traits (NEST) predictive modeling tool to present data in a context that illuminates factors and structural variables that contribute to disparities in health outcomes.
- Collect the following proposed outcomes measures related to maternal health:
  a. Percentage of low birthweight babies
  b. Timeliness of prenatal care
  c. C-section rates for low-risk first-birth women
  d. Postpartum care
  e. Elective delivery rate

Social Determinants of Health

LHCC reported the following:

- LHCC developed a community grants program and funded over 20 locally driven interventions to provide stable food and nutrition (e.g., building food pantries integrated into federally qualified health centers (FQHCs), expanding maternity nutrition services, and deploying mobile produce markets to food deserts across the State).

- Partner with community-based organizations (CBOs) on social determinants of health (SDOH) interventions and funding.
- Identify SDOH gaps using data and analytics.
- Partnered with Shreveport Farmers' Market for the double-up SNAP match program.
- Launched a provider campaign to promote the use of Z codes to indicate SDOH factors on a claim
- CHWs perform in-person outreach to address SDOH.

Community, Provider, and Member Engagement Initiatives

LHCC reported the following:

- Develop meaningful partnerships with CBOs and anchor community entities, such as local United Way and Urban League chapters, to conduct trainings on health equity, unconscious bias, and anti-racism and conduct health equity formative research.
- Partner with provider organizations to offer Cost of Poverty Experience (COPE) cultural sensitivity training virtually and as a free session at educational conferences.
- Leverage information obtained from neighborhood councils and community centers to design initiatives.
- Invest in the community where we live, play, and pray.
- Ensure the provider network is providing culturally competent services with humility by building awareness of culture.
- Offer continuing education units (CEUs) for providers to complete implicit bias and health equity training.
- Select CHWs with lived experiences in all nine regions to receive training to become certified adverse childhood experiences (ACE) educators.
- Increase provider capacity via regionally based peer support specialists.
- Develop Health Equity Neighborhood Initiatives to identify and address disparities.
- Convene the neighborhood councils (comprised of CBOs, community residents, providers, local government agencies, and other stakeholders) to develop a collaborative health equity neighborhood action plan.
- Locate community wellness centers within each health equity neighborhood.
- Ongoing engagement with locally run neighborhood councils to engage community members and providers and to solicit direct feedback.
- Host roundtable sessions, which include physician practices and ethnic communities to provide information about the needs of the enrollee groups and enlist help from the provider practices.
- Offer information about the benefits of immunizations and well-child visits and provide on-site services such as immunization events.
- Collaborate with schools, summer programs, and Head Start programs to develop and provide education to parents in the areas of greatest need.

- Use of LHCC's mobile dental van to bring oral health screenings and education to Louisiana schools in targeted rural communities.
- To increase preventive dental services among Native American enrollees, launch a targeted campaign to promote dental services.

Health Equity Plan Development Process

LHCC reported completing the following steps to developing the HEP:

- Ensuring the provider network is providing culturally and linguistically appropriate services through review of organizational practices, hiring practices, and training
- Collecting and analyzing enrollee language data to stay informed of local/regional needs
- Promoting cultural humility
- Obtaining feedback from the community
- Messaging testing
- Leveraging existing research and industry knowledge
- Engaging CBOs and other anchor community organizations and agencies
- Leveraging data sharing
- Supporting providers

Health Equity Action Plan by Focus Area

Table A-1 describes LHCC'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. Training	• Health equity training to all LHCC staff • Cultural responsiveness and implicit bias training • Childhood adversity and trauma training	By December 2023: • Initiate annual health equity, cultural competency, and implicit bias training for all staff • 95 percent of LHCC staff will complete training • Deploy training to LHCC	• Educate the LHCC staff on the impacts of health inequities across at-risk populations • Educate providers and staff about how to become culturally responsive and avoid implicit bias	• Provide health equity, c competency, and implicit bias training annually to all LHCC staff and network providers • Tracking for training, compliance, and follow up for staff	• All LHCC staff • Network providers • Case Management (CM) staff

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		• Implement an attestation process to obtain training completion from providers during re-credentialing • New and existing staff hired will complete trauma-informed care and ACEs training • All CHWs will enroll to become certified ACE educators	• Educate the LHCC staff about the of impacts of childhood adversity and trauma	and providers • Offer CEUs for providers to complete health-equity and cultural competency related trainings • Provide trauma-informed care and ACEs training to all newly hired LHCC staff	
B. Social Determinants of Health	• Community resource list • Sharing SDOH needs with network providers • Reimbursing network providers • Identifying SDOH needs for enrollees	By December 2023: • 100 percent of member-facing PHCO staff utilizing findhelp.org • 100 percent of referrals made through findhelp.org and Louisiana United Way (LAUW)/211 are entered in LHCC's clinical documentation assessment to track SDOH needs and success of the referral • Integrate findhelp.org into LHCC's internal referral platform	• Contract with findhelp.org • Integrate workflows • Measure staff impacts on community outcomes • Partner with LAUW/211 for access to their community services directory • Engage community members and providers, and solicit direct feedback through field-based enrollee and provider-facing staff • Inform CM of member needs	• When SDOH needs are identified, CM staff complete a referral assessment that tracks the success and completion of the referral • When a provider refers an enrollee with SDOH needs, LHCC's CM dept or CHWs will follow up with the provider to provide an update	• CHWs • Findhelp.org (formerly Aunt Bertha) • LAUW/211 • Community-at-large • Network providers • Enrollees • LHCC staff (Marketing, CM, Analytics, Claims, Provider Network and Contracting, and Vendor Management)

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		• Establish baseline usage and referral trends to develop targets for 2024 utilization • Provider relations staff will meet with 100 percent new incoming providers to educate on the process of referrals for enrollees with needs • Assess and utilize the disparity data to identify primary care providers (PCP) in areas with the highest disparities and SDOH needs • Provider Relations staff to meet with all PCP providers and include education of how to send SDOH needs referrals to CM • Evaluate Z code usage and determine correlations of identified SDOH concentrated areas of need • Review data to create provider	via data produced from the health needs assessment (HNA) and the SDOH dashboard • Continue to add community partnerships • Use of MOUs to support data sharing and collaboration • Promote the use of Z codes to indicate SDOH factors on a claim • Provide the Food Insecurity Toolkit to providers • Provide targeted outreach to identify and address trends to share with providers and community partners • Complete a HNA within the first 90 days for each enrollee	• Continue to analyze SDOH data annually and share with providers and community partners	

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		cohort and partners • Complete clinical staff training on resource assessment • Evaluate the effectiveness of the resource assessment and update the tool as appropriate			
C. Community Approach	• Neighborhood Health Equity (HE) Project • Community engagement activities • Community wellness centers • Community partnership expansion	By December 2023: • Establish one HE neighborhood based on current disparity data • Refresh and reassess disparity report data post go-live to refine the HE neighborhood initiative • Establish community partners to participate in HE Neighborhood Council • Evaluate current partnerships and determine if additional partnerships are needed to address region-specific needs • Develop and deploy surveys to providers, community partners, and	• Engage established, anchor community entities such as the local United Way and Urban League chapters • Partner with community entities on SDOH interventions and funding • Convene CBOs in each HE Neighborhood to develop a collaborative action plan • Expand current community engagement activities • Open nine Community Wellness Centers strategically located throughout Louisiana to	• Conduct health equity formative research on local lived experience and needs • Host events that address region specific needs • Identify existing resources in the community that effectively address health and SDOH inequities • Enhance health and SDOH programming in the communities	• LHCC Community Innovations Team • Quality staff • Local community entities • Community-at-large • Providers

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		community at large • Host at least 1 community event per quarter in each region • Open 2 community wellness centers and begin to host events at the community wellness centers • Develop activity tracking and feedback mechanism • Develop an asset inventory tool that identifies resources to address health and SDOH inequities in the community	support community events • Provide resources and administrative support to enhance service provision in addressing health and SDOH inequities		
D. Inequities in Care	• Improve pregnancy and birth outcomes by addressing inequities experienced by Black enrollees • Enrollee and family feedback to identify and execute program improvements • Decrease disparities for children and adolescents • Improve well-child visits and	By December 2023: • Daily Notice of Pregnancy (NOP) reports for outreach • Post-prenatal appointment screeners on each CM follow up • Daily acuity review from the deliveries report • Conduct a minimum of one MAC meeting per quarter • Increase the deployment of	• Evaluate the eff • Use data on daily NOP reports to conduct outreach • Conduct post-appointment	• Refer enrollees identified with SDOH needs to resources as needed • CHW staff will facilitate enrollee and community baby showers that will include education about doula services and SUD services • Use existing meeting	• LHCC CM Team • Clinical Operations (analytical data) • Community Innovations Team • Network providers • Marketing • Local schools • Local FQHCs • Quality staff • Local vendors

Focus Area	Goals	Objectives	Strategies	Activities	Participants
	vaccination rates • Improve preventive dental services	multi-modal surveys for identified enrollees, providers, and community partners, to solicit feedback on areas of opportunity by 5 percent • Increase quarterly participation in MAC meetings by 5 percent • Document SDOH referrals in the resource assessment • Develop reporting mechanism to track referrals across regions • Evaluate feedback and referral data to establish 2024 performance improvement baseline • Refresh RELD data to inform 2024 program enhancements • Increase provider and community partnerships and collaborations for community events by 25 percent • Increase enrollees	screenings during a CM follow-up to verify enrollees' comfort level with providers • Capture enrollee feedback to identify and execute program improvements • Review acuity from the deliveries report to identify enrollees at risk for preeclampsia and depression • CHWs will assist with community events within areas identified with greatest disparities, to provide resources and connection to CM • Utilize a mobile unit to provide oral health screenings with LHCC's school partnerships • Identify children and adolescents who may have	forums to solicit enrollee and family feedback • Utilize SDOH data to improve targeted initiatives addressing disparities • Use data to partner with providers throughout the state to increase access to oral screenings	

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		screened for ACEs by 5 percent • Review baseline data to establish additional areas of disparity • Improve well-child visits and vaccination rates by 2 percent in identified disparity populations • Develop a community tracking tool to identify additional community partnerships • Increase deployment of mobile dental vans for oral health screenings by 25 percent • Improve fluoride varnish applications by 2 percent in identified pediatric disparity populations • Develop health literacy programming in partnership schools	been impacted by trauma • Team up with community partners to host statewide vaccination events		
E. Quality Improvement	• Advancing health equity and enrollee outcomes through the use	By December 2023: • Increase enrollee outreach and	• Evaluate data such as ED visits, hospital utilizations, utilization of	• Conduct monthly member surveys and quarterly	• LHCC CM Team • Clinical Operations (analytical data) • Analytics Team

Focus Area	Goals	Objectives	Strategies	Activities	Participants
	of CHWs and PSS • RELD and geographic data • CLAS	engagement by 25 percent • Deploy survey tools to enrollees to solicit feedback and measure satisfaction • Assemble Enrollee Advisory Groups to inform usage of CHWs and peer support specialist • Evaluate satisfaction/ feedback data to establish 2024 performance improvements • Compare and analyze year over year CAHPS supplemental questions survey responses related to CLAS for trends	SUD services, and • Continue to assess enrollee satisfaction, feedback, and suggestions • Use culturally appropriate communication methods such as newsletters, mailings, LHCC's public website, and enrollee-facing staff • Use an industry-leading model to reliably attribute race/ethnicity based on local demographics, allowing accurate identification of disparities • Add CLAS related supplemental questions to the CAHPS survey	enrollee advisory groups • Use data and feedback mechanisms to measure the effectiveness of CHWs and PSS for program refinement • An annual evaluation of enrollee language needs, alternate formats, age group, gender, race, and ethnicity • Use of analytics and artificial intelligence to predict a person's ethnicity based on first name, surname, and nine-digit ZIP Code	• Marketing • Member and Provider Services • Quality staff, • Community Innovations team

Plan to Conduct Cultural Responsiveness and Implicit Bias Training

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

- Annual cultural competency training for staff with a 95 percent completion rate with the following learning goals:
  - Define cultural humility and identify the impacts of cultural differences in healthcare across at-risk populations.
  - Describe laws and tools available that can be used to provide culturally sensitive care.
  - Outline next steps to take to provide culturally relevant care and support.
  - Apply what was learned by appropriately resolving practice scenarios.
- Offer CEUs for providers to complete implicit bias and health equity training. LHCC will require all network providers to complete health equity training using a "no wrong door" approach, allowing providers to fulfill requirements through any entity, including another MCO, their own organization, or another provider group or CBO.
- Track provider completion of trainings through an attestation linked to the re-credentialing process.
- Support providers with training and education on topics such as cultural sensitivity, implicit bias, clear communication, and the practices and needs of specific populations in their service area.
- CLAS standards are included in the LHCC provider orientation and handbook.
- CLAS handouts are provided on each provider visit.

Stratify MCO Results on Attachment H Measures

In its HEP submission, LHCC submitted preliminary measure rates stratified only by race; however, LHCC reported that in 2023 it will summarize baseline information on Attachment H measures, using stratification if available.

Appendix B. Compliance Review Remediation Follow-Up

Appendix B includes LHCC's response to the CAP recommendations made by the previous EQRO for addressing deficiencies from the prior year's CR and HSAG's findings after reviewing LHCC's responses and additional documentation. Please note that the responses in this section were provided by the plans and have not been edited by HSAG.

Recommendations
Requirement: *In compliance with applicable quality assurance and utilization management standards.* This requirement is not addressed by the Care Plan Development and Implementation Process or the Care Management Program Description. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to include this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: Vague language in the contract resulting in misinterpretation.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member.* Of the 10 case management files reviewed, three (3) files met the requirement and seven (7) files were not applicable. Of the 10 behavioral health case management files reviewed, two (2) files met the requirement and eight (8) files were not applicable. This requirement is not addressed by the Care Plan Development and Implementation Process or the Care Management Program Description. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to include verbiage "individualized treatment plan" instead of "plan of care" to meet this requirement. All CM and BH files met this criteria or were N/A. Note, in 2023 contract, this verbiage was changed to include "The individualized treatment plan is reviewed and revised upon reassessment of functional need. The

POC revisions will occur at least at the frequency required in the Tiered Case Management requirements or when the enrollee's circumstances or needs change significantly (new problem, goal, barrier, or acuity change), or at the request of the enrollee, parent or legal guardian, or a member of the multi-disciplinary team. (Model Contract 2.7.8.4)" which is currently reflected in LA.CM.01 Care Management Program Description.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.* Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, all 10 files met the requirement. This requirement is partially addressed by the Care Plan Development and Implementation Process on page 1 and the Care Management Program Description on pages 28 and 30. LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to include verbiage regarding the "The person-centered integrated plan of care, developed by the Care Manager, will be completed within thirty (30) calendar days of the provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) (Emergency Contract 6.19.4.4)." to meet this requirement. All CM and BH files were compliant with this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.

HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider.* Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, nine (9) files met the requirement. One (1) file (BH#8) did not meet the requirement: the member identified a PCP in the assessment, but there is no documentation in the file that LHCC attempted outreach to this provider. This requirement is partially addressed by the LA Healthcare Connections 2021 Provider Manual on page 56. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination. Additionally, LHCC should ensure that communication is established with identified PCPs.
Response
Describe initiatives implemented based on recommendations: Care Managers were educated across multiple weeks in September 2022 on importance of identifying all providers involved in member's care as well as guidelines on when to follow-up with providers regarding care plan updates. LHCC will ensure that communication is established and documented accordingly with identified Primary Care Providers (PCPs). LHCC did not have to update the policy, LA.CM.01 Care Management Program Description, to meet this requirement. Instead, the policy was annotated to reflect verbiage that was already within policy at time of survey for post submission.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Noted improvement within internal audit monitoring regarding identification of the member's active providers, including PCP, and collaboration with providers.
Identify any barriers to implementing initiatives: Member refusal to allow Care Manager to communicate with provider
Identify strategy for continued improvement or overcoming identified barriers: Internal monitoring of files completed an internal audit team. Findings reviewed and discussed in bi-weekly leadership meeting. Leaders encourage staff in bi-weekly staff meetings to engage with PCPs and report issues with unreceptive providers.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems.* *Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall*

ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH.

This requirement is partially addressed by the Continuity and Coordination of Services Policy. LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination.

Response

Describe initiatives implemented based on recommendations:

Louisiana Healthcare Connections (LHCC) updated the LA.UM.16 Continuity and Coordination of Services Policy to include verbiage regarding the "Continuity of care activities shall provide processes by which the Plan members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The Plan shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and explanations of benefits (EOBs) to identify and overcome barriers to primary and preventive care that a Plan member may encounter. Corrective action shall be undertaken by the Plan on an as needed basis and as determined by LDH. (Emergency Contract 6.30.0)" to meet this requirement.

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

All Utilization Management (UM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.

Identify any barriers to implementing initiatives:

None Identified.

Identify strategy for continued improvement or overcoming identified barriers:

The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.

HSAG Assessment

The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.

Recommendations

Requirement: *Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses.*

Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, all 10 files met the requirement. The requirement is partially addressed by the ICC Rounds system screenshots, the ICC Rounds Schedule, and the Continuity and Coordination of Services Policy on page 2. The requirement is partially addressed by the ICC Rounds system screenshots, the ICC Rounds Schedule, and the Continuity and Coordination of Services Policy on page 2.

Response

Describe initiatives implemented based on recommendations:

Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to include verbiage regarding the "During this time, the Case Management staff will provide the member with information on how to contact the Care Manager to assist with coordinating services the member accesses (Emergency Contract 6.30.2.3)." to meet this requirement. LA.UM.16 Continuity and Coordination of Services policy was also updated to reflect verbiage regarding "The new members will also be provided with the Plan

service information such as emergency numbers and instructions on how to obtain services (Emergency Contract 6.30.2.3". All CM and BH files were compliant with this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Coordinate care between network PCPs and specialists; including specialized behavioral health providers; Coordinate care for out-of-network services, including specialty care services; Coordinate MCO provided services with services the member may receive from other health care providers.* This requirement is partially addressed by the DCFS Rounds document and the Continuity and Coordination. LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.UM.16 Continuity and Coordination of Services Policy to include verbiage regarding "The ICT will facilitate communication and coordination between the PCP, Specialists and other health care providers, including behavioral health providers, as needed to ensure continuity of care and prevent duplication of services. This is especially important for complex or special needs cases as they often see several providers to manage their condition. Providers are educated on the importance of cross-communication in the Provider Handbook and ad-hoc training sessions. Compliance will be monitored during bi-annual medical record reviews. (Emergency Contract 6.30.2.4-6.30.2.6)" to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Utilization Management (UM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None Identified
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The individualized treatment plans must be: Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists*

caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.

This requirement is partially addressed by the Care Management Program Description on page 32 and the LA Healthcare Connections 2021 Provider Manual on page 56. LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination. Additionally, LHCC should ensure that communication with the PCP is established in order to acquire the individualized treatment plan.

Response

Describe initiatives implemented based on recommendations:
Care Managers were educated across multiple weeks in September 2022 the importance of identifying all providers involved in member's care as well as guidelines on when to follow-up with providers regarding care plan updates. LHCC will ensure that communication is established and documented accordingly with identified Primary Care Providers (PCPs). Louisiana Healthcare Connections (LHCC) also updated the LA.CM.01 Care Management Program Description Policy to include verbiage regarding the "In addition to the person-centered integrated plan of care, an individualized treatment plan is developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment (Emergency Contract 6.19.4.1)." to meet this requirement.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Noted improvement within internal audit monitoring regarding identification of the member's active providers, including PCP, and collaboration with providers.

Identify any barriers to implementing initiatives:
Member refusal to allow Care Manager to communicate with provider.

Identify strategy for continued improvement or overcoming identified barriers:
Internal monitoring of files completed an internal audit team. Findings reviewed and discussed in bi-weekly leadership meeting. Leaders encourage staff in bi-weekly staff meetings to engage with PCPs and report issues with unreceptive providers.

HSAG Assessment

The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.

Recommendations

Requirement: *Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate.*

This requirement is partially addressed by the LA Healthcare Connections Provider Manual on pages 106 and 107. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.

Response

Describe initiatives implemented based on recommendations:
Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to show verbiage regarding "The goal of our ED Diversion Program is to decrease inappropriate ED utilization through the redirection of members to appropriate levels of care, including referral to community

behavioral health specialists for behavioral health emergencies. A specialized Integrated Care Team, consisting of experienced Care Managers, Social Workers and Behavioral Health Care Managers, focuses on access to care issues and resource education. Interventions include linking the member to a PCP, educating them about and helping them to access transportation, and providing education on the importance of getting the right care, at the right time, in the right setting." to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Documenting authorized referrals in the MCO's clinical management system.* This requirement is partially addressed by the referrals screenshots referenced. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to show verbiage regarding "Referrals, assessments, care plans, and all Case Management activities are documented in a central clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries (Emergency Contract 6.36.9.1.10)." to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Developing capacity for enhanced rates or incentives for integrated care by providers.* This requirement is partially addressed by the LA Healthcare Connections Provider Manual and the Amendment of the Provider Contract. LHCC submitted documentation that shows how this requirement is communicated to providers; however, in addition to the communication component, the structure component in

the form of a policy, procedure, or program description is needed. LHCC should create a policy, procedure, or program description to address this requirement.
Response
Describe initiatives implemented based on recommendations: Developed policy LA.QI.23 which outlines the P4P program as follow up evidence to last year's compliance review per the recommendation.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): After modifying provider incentives, 9 of 11 measures are showing an upward trend compared to previous year.
Identify any barriers to implementing initiatives: Feedback from providers highlighted staffing shortages, member no shows and uncertainty with redetermination as significant concerns. Modified and enhanced incentives for measures that were not trending positively.
Identify strategy for continued improvement or overcoming identified barriers: Exploring other incentive models that increase transition of care visits. Created a value based and quality support team that includes Clinical Nurse Liaisons.
HSAG Assessment
The documents submitted by the MCO did not address the recommendation from the 2022 CR, and the MCO was unable to demonstrate compliance during the virtual review. The MCO must address this recommendation to remediate the finding.
Recommendations
Requirement: *Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures.* This requirement is partially addressed by the Care Management Learning Compass, the BH Screening Tools presentation, the training website screenshot, and the provider orientation slide. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to show verbiage regarding the "All CM staff are provided training upon hire and as needed regarding CM assessments and screenings, which include identification and screening of behavioral health conditions and referral procedures (Emergency Contract 6.36.8 and 6.36.9.1.12)" to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.

Recommendations
Requirement: *Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team.* The requirement is partially addressed by the ICC Rounds system screenshots and by the ICC Rounds Schedule. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to show verbiage regarding "The CM staff conduct case management rounds at least monthly, which includes the Behavioral Health Care Managers and Behavioral Health Medical Directors (Emergency Contract 6.36.9.1.13)." to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.* This requirement is partially addressed by the DCFS Rounds document. LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the LA.CM.01 Care Management Program Description Policy to show verbiage regarding "In addition, CM staff participate in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication (Emergency Contract 6.36.9.1.14). " to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All Care Management (CM) policies and procedures will be reviewed annually for accuracy. Revisions will be made as needed from contract amendments and updates to policies and procedures.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all policies are reviewed annually and updated with new contract language as applicable.

HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.* Eight (8) of 10 files met the requirements; the remaining 2 files did not have language that appeared to be easily understood. Case 1 and 7 Fisher and Brumfield. This requirement is addressed in the Adverse Determination (Denial) Notices policy and procedure, but was only partially met in the file review. The plan provided the language in the MCO comments section and an updated document showing how their correspondence unit will meet this going forward. No further action is required.
Response
Describe initiatives implemented based on recommendations: Louisiana Healthcare Connections (LHCC) updated the job aide regarding how to process adverse determinations to ensure the letter is in easily understood language. LHCC incorporated the Flesh Kincaid application to check the appropriate grade level.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Nurses denial letters are audited every month using an audited tool implemented to make sure member denial verbiage is at the appropriate grade level for the plan.
Identify any barriers to implementing initiatives: None identified
Identify strategy for continued improvement or overcoming identified barriers: The strategy for continuous improvement will include ensuring all adverse notification letters are reviewed before being sent out to ensure they are in easily understandable language. All Correspondence Unit staff will continuously be educated on how to review each adverse determination letter for easily understood language.
HSAG Assessment
The documents submitted by the MCO did not address the recommendation from the 2022 CR, and the MCO was unable to demonstrate compliance during the virtual review. The MCO must address this recommendation to remediate the finding.
Recommendations
Requirement: *The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.* This requirement is partially addressed by the Provider Termination Policy and the sample member notification letters provided. LHCC should incorporate this requirement into a policy.
Response
Describe initiatives implemented based on recommendations: The Recommendations above were incorporated into Provider Termination Policy [LA.MBRS.27] by the LHCC Provider Eligibility Team. Policies and procedures and training has been updated. Additionally, staff

received training and are in ongoing process improvement and auditing of Provider Terminations and reassignments weekly.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): LHCC Provider Eligibility Team has improved our internal work process to complete all work and send written notices out within the 7 calendar day turnaround time, thus reducing the risk of missing the TAT due to a misinterpretation of the type of provider termination and member impact.
Identify any barriers to implementing initiatives: No Barriers Reported in Implementation.
Identify strategy for continued improvement or overcoming identified barriers: We're coordinating with data solutions for our continuous improvement portion below to support trending methodologies to identify areas of risk proactively. Provider Termination Ticket submission for reassignments can be automated to reduce risk of human error.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.* This requirement is partially addressed by the Provider Termination Policy and the sample member notification letters provided. LHCC should incorporate this requirement into a policy.
Response
Describe initiatives implemented based on recommendations: The Recommendations above were incorporated into Provider Termination Policy [LA.MBRS.27] by the LHCC Provider Eligibility Team. Additionally, staff received training and are in ongoing process improvement and auditing of Provider Terminations and reassignments weekly.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): LHCC Provider Eligibility Team has improved our internal work process to complete all work and send written notices out within the 7 calendar day turnaround time, thus reducing the risk of missing the TAT due to a misinterpretation of the type of provider termination and member impact.
Identify any barriers to implementing initiatives: No Barriers Reported in Implementation.
Identify strategy for continued improvement or overcoming identified barriers: We're coordinating with data solutions for our continuous improvement portion below to support trending methodologies to identify areas of risk proactively. Provider Termination Ticket submission for reassignments can be automated to reduce risk of human error.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.

Recommendations
Requirement: *Revocation of the provider's home and community-based services license or behavioral health service license.* The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period. No action is required by LHCC, as this issue was self-identified and added to the updated policy.
Response
Describe initiatives implemented based on recommendations: The health plan's Fraud, Waste and Abuse Plan underwent a revision to incorporate the new Model Contract provisions. The health plan conducts policy reviews monthly to ensure policies are updated to reflect current contract and regulatory requirements.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): There were no performance improvement initiatives identified or implemented because of the policy revisions throughout this document.
Identify any barriers to implementing initiatives: There were no barriers prohibiting the health plan's ability to implement the updated provisions within the policy to align appropriately with the new Model Contract.
Identify strategy for continued improvement or overcoming identified barriers: The health plan, through its compliance department, manages a cross-functional policy committee responsible for approving operational policies on an annual review cycle. Policies are maintained in a document repository inclusive of an annual review date. Based on the review date, the policy manager ensures policies are included on the committee agenda for review/approval. As contract amendments or regulatory changes arise, policies are updated appropriately and submitted to the committee for review/approval. The oversight and policy management process serves to ensure that our compliance with contractual and regulatory requirements are met.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Exclusion from the Medicaid program.* The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period. No action is required by LHCC, as this issue was self-identified and added to the updated policy.
Response
Describe initiatives implemented based on recommendations: The health plan's Fraud, Waste and Abuse Plan underwent a revision to incorporate the new Model Contract provisions. The health plan conducts policy reviews monthly to ensure policies are updated to reflect current contract and regulatory requirements.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): There were no performance improvement initiatives identified or implemented because of the policy revisions throughout this document.

Identify any barriers to implementing initiatives: There were no barriers prohibiting the health plan's ability to implement the updated provisions within the policy to align appropriately with the new Model Contract.
Identify strategy for continued improvement or overcoming identified barriers: The health plan, through its compliance department, manages a cross-functional policy committee responsible for approving operational policies on an annual review cycle. Policies are maintained in a document repository inclusive of an annual review date. Based on the review date, the policy manager ensures policies are included on the committee agenda for review/approval. As contract amendments or regulatory changes arise, policies are updated appropriately and submitted to the committee for review/approval. The oversight and policy management process serves to ensure that our compliance with contractual and regulatory requirements are met.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Termination from the Medicaid program.* The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period. No action is required by LHCC, as this issue was self-identified and added to the updated policy.
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HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.

Recommendations
Requirement: *Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41).* The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period. No action is required by LHCC, as this issue was self-identified and added to the updated policy.
Response
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HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50).* The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period. No action is required by LHCC, as this issue was self-identified and added to the updated policy.
Response
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HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The Louisiana Attorney General's Office has seized the assets of the service provider.* The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period. No action is required by LHCC, as this issue was self-identified and added to the updated policy.
Response
Describe initiatives implemented based on recommendations: The health plan's Fraud, Waste and Abuse Plan underwent a revision to incorporate the new Model Contract provisions. The health plan conducts policy reviews monthly to ensure policies are updated to reflect current contract and regulatory requirements.
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HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH- approved CAPs and compliance with the requirements.

Recommendations
Requirement: *The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.* The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period. No action is required by LHCC, as this issue was self-identified and added to the updated policy.
Response
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HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.