Managed Care Program Annual Report (MCPAR) for Louisiana: Healthy Louisiana

Due date	Last edited	Edited by	Status
06/29/2025	06/30/2025	Corneliaus Cole	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Louisiana
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Corneliaus Cole
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	corneliaus.cole@la.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Brandon Bueche
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	brandon.bueche@la.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/30/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2024
A6	**Program name** Auto-populated from report dashboard.	Healthy Louisiana

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

	Indicator	Response
	Plan name	Aetna Better Health of Louisiana AmeriHealth Caritas Louisiana Healthy Blue Louisiana Healthcare Connections UnitedHealthcare Community Plan Humana Healthy Horizons

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Maximus Health Services

Add In Lieu of Services and Settings (A.9)

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,726,145
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,578,450

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	EQRO

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	LDH PI section utilizes data mining runs/algorithms, risk scoring and alerts which focus on providers in both the Fee-For-Service (FFS) and Managed Care programs. Some of the algorithms and alerts include date of death runs, excluded provider runs, spike/surge runs, procedure code outlier runs, etc. The audits resulting from the methods mentioned above are conducted by the PI Internal SURS Unit or UPIC contractors; other audits/leads are sent to the Plans to review. In addition to data review, PI operates a complaint hotline. Both fee-for-service and managed care complaints are received via the hotline. The complaints are triaged and either is worked by the PI Internal SURS or the complaints are referred to the Plans. The PI Internal SURS also works closely with the Medicaid Fraud Control Unit (MFCU) in the Attorney General's office. Based on information discovered in audits and complaints, PI Internal SURS sends referrals to MFCU to investigate. MFCU works with SURS to initiate payment suspensions based on credible allegations of fraud. PI, SURS, MFCU and the Plan's Special Investigations Unit (SIU) have a monthly calls and quarterly meetings with the Plans.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	MCO Contract, Attachment A: Statement of Work, Sections 2.20.6.2-2.20.6.3
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain	All recoveries identified by the MCE are retained by the Plan. All recoveries identified by the State are retained by the State. If the MCE fails to collect at least a portion of the identified overpayment after 365 days the State may step

	overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	in and recover from the MCE and said funds would be retained by the State. If the MCE's recovery efforts are deemed sufficient then the State will not step in and recover the overpayment.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	All recoveries are reported by MCOs on two quarterly reports. The MCOs also report all identified overpayments and recovered overpayments on a monthly report. The PI MC Oversight unit conducts review seeking compliance with reporting requirements.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The State and the MCEs have a monthly and quarterly reconciliation 834 file.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state’s federal database checks, did the state	Yes

	find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.8b	**Federal database checks: Summarize instances of exclusion** Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.	Yes, Sonoran Desert Pathology and Landmark Diagnostics were identified and notified via certified letter of their exclusion from LA Medicaid in July 2024.
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter “No such audits were conducted during the reporting year” as your response. “N/A” is not an acceptable response.	Reviews conducted during CY2024 are published at https://ldh.la.gov/resources?cat=&d=5&y=0&q=EQR

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Louisiana Medicaid Managed Care Organization
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://ldh.la.gov/resources?q=Managed%20Care%20Organization%20%28MCO%29%20Executed%20Contracts%20for%20Contracting%20Period%20January%201%2C%202023%20to%20Present
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental Transportation

C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	Service area is statewide. There are four broad categories of coverage depending upon the population: (1) All covered services, (2) Specialized Behavioral Health Services and Non-Emergency Ambulance transportation, (3) Specialized Behavioral Health and NEMT Services including Non-Emergency Ambulance transportation, (4) All covered services except Specialized Behavioral Health and Coordinated System of Care (CSoC) services (CSoC Population).
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	1,578,450
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	1) Covid Unwind - The Procedure where LDH began enrollment of policy and procedures used prior to the PHE and the changes LDH made to have individuals enrolled and stay enrolled in a Medicaid TOA. Unwind brought back income limits, wage checks, tax checks, etc. 2) Began renewals, LWC wage checks, COLA batch runs and enacted The Work Number to verify wages again. Done in phases from May 2024 - Dec 2024

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Other, specify – Encounter submission completeness measured bimonthly as comparison of payments as reported in encounters vs payments reported in cash disbursement journals; encounter data completeness and accuracy also periodically evaluated via optional EQR Protocol 5.
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	MCO Contract, Attachment A: Statement of Work Section 2.18.15

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	MCO Contract, Attachment A: Statement of Work Sections 2.16, 2.18, 3.2 and Attachment G, Table of Monetary Penalties
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with “N/A” if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	Systems performance issues with Fiscal Intermediary (FI)(Gainwell Technologies) make it difficult to assess MCO non-compliance versus FI failures/non-compliance. On occasion, the state system denied encounters and void encounter transactions that appear in different from their corresponding cash disbursement journal (CDJ) transactions.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended.

C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	Some providers in the state do not want to credential with six different MCOs to administer their Medicaid line of business. Each MCO may have different policies and procedures, which increase the administrative burden on the provider and may necessitate additional staffing. Provider rates are another hindrance, as they are lower compared to Medicare or commercial carriers.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The contract with the MCOs requires paymentto out of network providers if there are gaps. LDH also works with the MCO when complaintsare made regarding the lack of a specialist in acertain area by looking at the market for the service area and requiring the MCO to outreach to those available providers that are not contracted with them. Further, the state mandates that MCOs submit Network Development Plans to identify gaps in network adequacy and outline recruitment efforts for new providers. The state uses this data to evaluate potential policy adjustments and rate increases, subject to available funding. Additionally, some behavioral health services may now be delivered via telehealth, following the COVID pandemic, when clinically appropriate and with the consent of the member served.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 94

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 94

C2.V.2 Measure standard

Adult PCP - 1:1,000 adult enrollees

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult

C2.V.7 Monitoring Methods

Reporting, Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 94

C2.V.2 Measure standard

Pediatric PCP - 1:1,000 child enrollees

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult

C2.V.7 Monitoring Methods

Reporting, Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

4 / 94

C2.V.2 Measure standard

10 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

5 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider
Primary care

C2.V.5 Region
Rural

C2.V.6 Population
Pediatric

C2.V.7 Monitoring Methods
Geomapping, Reporting

C2.V.8 Frequency of oversight methods
Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

6 / 94

C2.V.2 Measure standard
10 miles

C2.V.3 Standard type
Maximum distance to travel

C2.V.4 Provider
Primary care

C2.V.5 Region
Urban

C2.V.6 Population
Pediatric

C2.V.7 Monitoring Methods
Geomapping, Reporting

C2.V.8 Frequency of oversight methods
Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 94

C2.V.2 Measure standard
30 miles

C2.V.3 Standard type
Maximum distance to travel

C2.V.4 Provider
Hospital

C2.V.5 Region
Rural

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 94

C2.V.2 Measure standard

10 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

9 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Laboratory	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

10 / 94

C2.V.2 Measure standard

20 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Laboratory	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

11 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Radiology	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

12 / 94

C2.V.2 Measure standard

20 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Radiology	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

13 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

14 / 94

C2.V.2 Measure standard

10 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

15 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hemodialysis Centers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

16 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hemodialysis Centers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

17 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

18 / 94

C2.V.2 Measure standard

15 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

19 / 94

C2.V.2 Measure standard

Specialty Care - Allergy/Immunology - 1:100,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy/Immunology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

20 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy/Immunology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

21 / 94

C2.V.2 Measure standard

Specialty Care - Cardiology - 1:20,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

23 / 94

C2.V.2 Measure standard

Specialty Care - Dermatology - 1:40,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dermatology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dermatology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

25 / 94

C2.V.2 Measure standard

Specialty Care - Endocrinology and Metabolism - 1:25,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Endocrinology and Metabolism	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

26 / 94

C2.V.2 Measure standard

Specialty Care - Gastroenterology - 1:30,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Gastroenterology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

27 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Gastroenterology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

28 / 94

C2.V.2 Measure standard

Specialty Care - Hematology/Oncology - 1:80,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hematology/Oncology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

29 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hematology/Oncology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

30 / 94

C2.V.2 Measure standard

Specialty Care - Nephrology 1:50,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nephrology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

31 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nephrology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

32 / 94

C2.V.2 Measure standard

Specialty Care - Neurology - 1:35,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Neurology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reports

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

33 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Neurology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

34 / 94

C2.V.2 Measure standard

Specialty Care - Ophthalmology - 1:20,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Ophthalmology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

35 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Ophthalmology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

36 / 94

C2.V.2 Measure standard

Specialty Care - Orthopedics - 1:15,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Orthopedics	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

37 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Orthopedics	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

38 / 94

C2.V.2 Measure standard

Specialty Care - Otorhinolaryngology/ Otolaryngology - 1:30,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Otorhinolaryngology/ Otolaryngology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

39 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Otorhinolaryngology/ Otolaryngology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

40 / 94

C2.V.2 Measure standard

Specialty Care - Urology - 1:30,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

41 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

42 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Other Specialty Care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

43 / 94

C2.V.2 Measure standard

Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC) - 1:2,500

C2.V.3 Standard type

Linkage ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

44 / 94

C2.V.2 Measure standard

Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC) - 1:2,500

C2.V.3 Standard type

Linkage ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

45 / 94

C2.V.2 Measure standard

Emergency care - 24 hours, 7 days/week within 1 hour of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access, Enrollee surveys

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

46 / 94

C2.V.2 Measure standard

Urgent non-emergency care - 24 hours, 7 days/week within 24 hours of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent non-emergency care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

47 / 94

C2.V.2 Measure standard

Non-urgent sick primary care - 72 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Non-urgent sick primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

48 / 94

C2.V.2 Measure standard

Non-urgent routine primary care - 6 weeks

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Non-urgent routine primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

49 / 94

C2.V.2 Measure standard

After hours, by phone - Answer by live person or call-back from a designated medical practitioner within 30 minutes

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

50 / 94

C2.V.2 Measure standard

Ob/Gyn care for pregnant women - 1st Trimester - 14 days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Ob/Gyn care for pregnant women	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

51 / 94

C2.V.2 Measure standard

Ob/Gyn care for pregnant women - 2nd Trimester - 7 days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Ob/Gyn care for pregnant women	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

52 / 94

C2.V.2 Measure standard

Ob/Gyn care for pregnant women - 3rd Trimester - 3 days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Ob/Gyn care for pregnant women	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

53 / 94

C2.V.2 Measure standard

Ob/Gyn care for pregnant women - High risk pregnancy, any trimester - 3 days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Ob/Gyn care for pregnant women	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

54 / 94

C2.V.2 Measure standard

Family planning appointments - 1 week

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Family planning appointments	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

55 / 94

C2.V.2 Measure standard

Specialist appointments - 1 month

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Enrollee surveys, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

56 / 94

C2.V.2 Measure standard

Scheduled appointments - Less than a 45 minute wait in office

C2.V.3 Standard type

Waiting room time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All providers	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

57 / 94

C2.V.2 Measure standard

Provider is listed in directory and/or registry file as open to new patients

C2.V.3 Standard type

Accepting new patients

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All providers	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access, Secret shopper calls, Enrollee surveys

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

58 / 94

C2.V.2 Measure standard

Non-Urgent Routine - 14 days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

59 / 94

C2.V.2 Measure standard

Urgent Non-emergency Care - 48 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access, Secret shopper calls

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

60 / 94

C2.V.2 Measure standard

Psychiatric Inpatient Hospital (emergency involuntary) - 4 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Continuous monitoring of complaints

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

61 / 94

C2.V.2 Measure standard

Psychiatric Inpatient Hospital (involuntary) - 24 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Continuous monitoring of complaints

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

62 / 94

C2.V.2 Measure standard

Psychiatric Inpatient Hospital (voluntary) - 24 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Continuous monitoring of complaints

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

63 / 94

C2.V.2 Measure standard

ASAM Level 3.3, 3.5 & 3.7 - 10 business days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Continuous monitoring of complaints

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

64 / 94

C2.V.2 Measure standard

Residential Withdrawal Management - 24 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Continuous monitoring of complaints

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

65 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatrist	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

66 / 94

C2.V.2 Measure standard

15 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatrist	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

67 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral Health Specialist (Advanced Practice Registered Nurses with a BH specialty, Licensed and Medical Psychologist, & Licensed Clinical Social Worker)	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 68 / 94

C2.V.2 Measure standard

15 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral Health Specialist (Advanced Practice Registered Nurses with a BH specialty, Licensed and Medical Psychologist, & Licensed Clinical Social Worker)	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 69 / 94

C2.V.2 Measure standard

1:10,000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

70 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home Health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

71 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home Health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

72 / 94

C2.V.2 Measure standard

Adult Physician Extenders - 1:2,500

C2.V.3 Standard type

Linkage ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult

C2.V.7 Monitoring Methods

Reporting , Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

73 / 94

C2.V.2 Measure standard

Pediatric Physician Extenders - 1:1,000

C2.V.3 Standard type

Linkage ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

74 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider

Endocrinology and Metabolism

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

75 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider

Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

76 / 94

C2.V.2 Measure standard

60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

77 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM Level 1	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

78 / 94

C2.V.2 Measure standard

15 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM Level 1	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

79 / 94

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM Level 2.1	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

80 / 94

C2.V.2 Measure standard

15 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider
ASAM Level 2.1

C2.V.5 Region
Urban

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Reporting

C2.V.8 Frequency of oversight methods
Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

81 / 94

C2.V.2 Measure standard
60 miles

C2.V.3 Standard type
Maximum distance to travel

C2.V.4 Provider
ASAM Level 2WM

C2.V.5 Region
Statewide

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Reporting

C2.V.8 Frequency of oversight methods
Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

82 / 94

C2.V.2 Measure standard
30 Miles

C2.V.3 Standard type
Maximum distance to travel

C2.V.4 Provider
ASAM 3.1

C2.V.5 Region
Statewide

C2.V.6 Population
Adult

C2.V.7 Monitoring Methods
Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

83 / 94

C2.V.2 Measure standard

30 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM 3.3	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

84 / 94

C2.V.2 Measure standard

30 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM 3.5	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

85 / 94

C2.V.2 Measure standard

60 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM 3.2 Withdrawal Management	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

86 / 94

C2.V.2 Measure standard

60 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM 3.7	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

87 / 94

C2.V.2 Measure standard

60 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM 3.7 - Withdrawal Management	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

88 / 94

C2.V.2 Measure standard

60 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM Level 3.1	Statewide	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

89 / 94

C2.V.2 Measure standard

60 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM Level 3.2-Withdrawl Management	Statewide	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

90 / 94

C2.V.2 Measure standard

60 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ASAM Level 3.5	Statewide	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

91 / 94

C2.V.2 Measure standard

90 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Psychiatric Inpatient Hospital - Free Standing and Distinct Part Psychiatric Units	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

92 / 94

C2.V.2 Measure standard

200 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatric Residential Treatment Facilities	Statewide	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

93 / 94

C2.V.2 Measure standard

30 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Mental Health Rehabilitation Agency	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Reporting

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 94 / 94

C2.V.2 Measure standard

15 Miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental Health Rehabilitation Agency	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Reporting, Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	Healthy Louisiana mobile app (available for download on Apple and Android), https://myplan.healthy.la.gov/en
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	All correspondence informs enrollees that they can request assistance or auxiliary aids. This information is also provided on the website and in the mobile app.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	LTSS is not coordinated through the BSS.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Every interaction includes a customer satisfaction survey. There is also a complaint process through which enrollees can provide feedback. All complaints come directly to the State. The State also monitors performance of the BSS call center through tracking of routine KPIs.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	State
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	03/01/2021
C1XII.9	**When was the last parity analysis(es) for this program**	03/01/2021

	submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://ldh.la.gov/assets/docs/BehavioralHealth/Louisiana-Parity-Report-Act-421_V2-rev-03012021.pdf

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Aetna Better Health of Louisiana** 155,196 **AmeriHealth Caritas Louisiana** 177,845 **Healthy Blue** 286,430 **Louisiana Healthcare Connections** 439,176 **UnitedHealthcare Community Plan** 384,327 **Humana Healthy Horizons** 135,476
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Aetna Better Health of Louisiana** 9% **AmeriHealth Caritas Louisiana** 10.3% **Healthy Blue** 16.6% **Louisiana Healthcare Connections** 25.4% **UnitedHealthcare Community Plan** 22.3% **Humana Healthy Horizons** 7.8%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care	**Aetna Better Health of Louisiana** 9.8% **AmeriHealth Caritas Louisiana** 11.3% **Healthy Blue** 18.1% **Louisiana Healthcare Connections**

enrollment (B.I.2)	27.8% **UnitedHealthcare Community Plan** 24.3% **Humana Healthy Horizons** 8.6%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Aetna Better Health of Louisiana** 93.8% **AmeriHealth Caritas Louisiana** 94.8% **Healthy Blue** 99.4% **Louisiana Healthcare Connections** 97.3% **UnitedHealthcare Community Plan** 97.9% **Humana Healthy Horizons** 96.1%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Aetna Better Health of Louisiana** Program-specific statewide **AmeriHealth Caritas Louisiana** Program-specific statewide **Healthy Blue** Program-specific statewide **Louisiana Healthcare Connections** Program-specific statewide **UnitedHealthcare Community Plan** Program-specific statewide **Humana Healthy Horizons** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS	**Aetna Better Health of Louisiana** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for

	or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	Expansion is 95.3% and Non-Expansion is 92.3%. **AmeriHealth Caritas Louisiana** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for Expansion is 95.7% and Non-Expansion is 93.9%. **Healthy Blue** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for Expansion is 97.9% and Non-Expansion is 100.9%. **Louisiana Healthcare Connections** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for Expansion is 97.1% and Non-Expansion is 97.5%. **UnitedHealthcare Community Plan** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for Expansion is 97.4% and Non-Expansion is 98.4%. **Humana Healthy Horizons** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for Expansion is 98.9% and Non-Expansion is 93.3%.
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Aetna Better Health of Louisiana** Yes **AmeriHealth Caritas Louisiana** Yes

		Healthy Blue Yes **Louisiana Healthcare Connections** Yes **UnitedHealthcare Community Plan** Yes **Humana Healthy Horizons** Yes
N/A	Enter the start date.	**Aetna Better Health of Louisiana** 07/01/2023 **AmeriHealth Caritas Louisiana** 07/01/2023 **Healthy Blue** 07/01/2023 **Louisiana Healthcare Connections** 07/01/2023 **UnitedHealthcare Community Plan** 07/01/2023 **Humana Healthy Horizons** 07/01/2023
N/A	Enter the end date.	**Aetna Better Health of Louisiana** 06/30/2024 **AmeriHealth Caritas Louisiana** 06/30/2024 **Healthy Blue** 06/30/2024 **Louisiana Healthcare Connections** 06/30/2024 **UnitedHealthcare Community Plan** 06/30/2024 **Humana Healthy Horizons**

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Aetna Better Health of Louisiana** The MCO is responsible for ensuring accurate and complete encounter reporting from their providers. The MCO must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction. **AmeriHealth Caritas Louisiana** The MCO is responsible for ensuring accurate and complete encounter reporting from their providers. The MCO must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction. **Healthy Blue** The MCO is responsible for ensuring accurate and complete encounter reporting from their providers. The MCO must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction. **Louisiana Healthcare Connections** The MCO is responsible for ensuring accurate and complete encounter reporting from their providers. The MCO must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction. **UnitedHealthcare Community Plan** The MCO is responsible for ensuring accurate and complete encounter reporting from their providers. The MCO must evaluate the adequacy of, and revise if necessary, the

		encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction. **Humana Healthy Horizons** The MCO is responsible for ensuring accurate and complete encounter reporting from their providers. The MCO must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Aetna Better Health of Louisiana** 97% **AmeriHealth Caritas Louisiana** 94% **Healthy Blue** 89% **Louisiana Healthcare Connections** 93% **UnitedHealthcare Community Plan** 97% **Humana Healthy Horizons** 77%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Aetna Better Health of Louisiana** NA **AmeriHealth Caritas Louisiana** NA **Healthy Blue** NA **Louisiana Healthcare Connections** NA **UnitedHealthcare Community Plan** NA

Humana Healthy Horizons

NA

Topic IV. Appeals, State Fair Hearings & Grievances

> ⚠ **Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".**

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Aetna Better Health of Louisiana** 375 **AmeriHealth Caritas Louisiana** 459 **Healthy Blue** 1,211 **Louisiana Healthcare Connections** 1,698 **UnitedHealthcare Community Plan** 1,307 **Humana Healthy Horizons** 120
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter "N/A".	**Aetna Better Health of Louisiana** 4 **AmeriHealth Caritas Louisiana** 37 **Healthy Blue** 277 **Louisiana Healthcare Connections** 1 **UnitedHealthcare Community Plan** 244 **Humana Healthy Horizons** 11
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter "N/A".	**Aetna Better Health of Louisiana** 7 **AmeriHealth Caritas Louisiana** 1 **Healthy Blue** 19 **Louisiana Healthcare Connections**

		54 **UnitedHealthcare Community Plan** 29 **Humana Healthy Horizons** 1
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Aetna Better Health of Louisiana** 115 **AmeriHealth Caritas Louisiana** 182 **Healthy Blue** 223 **Louisiana Healthcare Connections** 771 **UnitedHealthcare Community Plan** 360 **Humana Healthy Horizons** 37
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Aetna Better Health of Louisiana** 1 **AmeriHealth Caritas Louisiana** 16 **Healthy Blue** 47 **Louisiana Healthcare Connections** 79 **UnitedHealthcare Community Plan** 13 **Humana Healthy Horizons** 9
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf	**Aetna Better Health of Louisiana** N/A **AmeriHealth Caritas Louisiana** N/A

	of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Healthy Blue** N/A **Louisiana Healthcare Connections** N/A **UnitedHealthcare Community Plan** N/A **Humana Healthy Horizons** N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal	**Aetna Better Health of Louisiana** N/A **AmeriHealth Caritas Louisiana** N/A **Healthy Blue** N/A **Louisiana Healthcare Connections** N/A **UnitedHealthcare Community Plan** N/A **Humana Healthy Horizons** N/A

	during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Aetna Better Health of Louisiana** 343 **AmeriHealth Caritas Louisiana** 346 **Healthy Blue** 1,054 **Louisiana Healthcare Connections** 1,592 **UnitedHealthcare Community Plan** 651 **Humana Healthy Horizons** 86
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Aetna Better Health of Louisiana** 7 **AmeriHealth Caritas Louisiana** 111 **Healthy Blue** 154 **Louisiana Healthcare Connections** 106 **UnitedHealthcare Community Plan** 633 **Humana Healthy Horizons** 24
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or	**Aetna Better Health of Louisiana** 372 **AmeriHealth Caritas Louisiana** 448 **Healthy Blue** 858

	limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Louisiana Healthcare Connections** 1,698 **UnitedHealthcare Community Plan** 1,092 **Humana Healthy Horizons** 82
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Aetna Better Health of Louisiana** 2 **AmeriHealth Caritas Louisiana** 10 **Healthy Blue** 53 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 8 **Humana Healthy Horizons** 3
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 1 **Healthy Blue** 300 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 207 **Humana Healthy Horizons** 35
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana**

	during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0

D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Aetna Better Health of Louisiana** 1 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Aetna Better Health of Louisiana** 48 **AmeriHealth Caritas Louisiana** 43 **Healthy Blue** 168 **Louisiana Healthcare Connections** 11 **UnitedHealthcare Community Plan** 253 **Humana Healthy Horizons** 17
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Aetna Better Health of Louisiana** 310 **AmeriHealth Caritas Louisiana** 357 **Healthy Blue** 763 **Louisiana Healthcare Connections** 1,567 **UnitedHealthcare Community Plan** 976 **Humana Healthy Horizons** 95
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Aetna Better Health of Louisiana** 10 **AmeriHealth Caritas Louisiana** 40 **Healthy Blue** 231 **Louisiana Healthcare Connections**

		69 **UnitedHealthcare Community Plan** 38 **Humana Healthy Horizons** 14
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	**Aetna Better Health of Louisiana** 22 **AmeriHealth Caritas Louisiana** 55 **Healthy Blue** 61 **Louisiana Healthcare Connections** 52 **UnitedHealthcare Community Plan** 72 **Humana Healthy Horizons** 4
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**Aetna Better Health of Louisiana** 104 **AmeriHealth Caritas Louisiana** 144 **Healthy Blue** 344 **Louisiana Healthcare Connections** 235 **UnitedHealthcare Community Plan** 430 **Humana Healthy Horizons** 32
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan	**Aetna Better Health of Louisiana** 6 **AmeriHealth Caritas Louisiana** 1

	during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**Healthy Blue** 6 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 28 **Humana Healthy Horizons** 2
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.	**Aetna Better Health of Louisiana** N/A **AmeriHealth Caritas Louisiana** N/A **Healthy Blue** N/A **Louisiana Healthcare Connections** N/A **UnitedHealthcare Community Plan** N/A **Humana Healthy Horizons** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**Aetna Better Health of Louisiana** 1 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 1 **Humana Healthy Horizons** 2

D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter “N/A”.	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Aetna Better Health of Louisiana** 14 **AmeriHealth Caritas Louisiana** 7 **Healthy Blue** 9 **Louisiana Healthcare Connections** 52 **UnitedHealthcare Community Plan** 43 **Humana Healthy Horizons** 4
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 1 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Aetna Better Health of Louisiana** 8 **AmeriHealth Caritas Louisiana** 9 **Healthy Blue** 17 **Louisiana Healthcare Connections**

		43 **UnitedHealthcare Community Plan** 31 **Humana Healthy Horizons** 2
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Aetna Better Health of Louisiana** 2 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 3 **Louisiana Healthcare Connections** 5 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter “N/A”. External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0

process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Aetna Better Health of Louisiana** 426 **AmeriHealth Caritas Louisiana** 273 **Healthy Blue** 927 **Louisiana Healthcare Connections** 1,520 **UnitedHealthcare Community Plan** 1,725 **Humana Healthy Horizons** 319
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Aetna Better Health of Louisiana** 27 **AmeriHealth Caritas Louisiana** 9 **Healthy Blue** 106 **Louisiana Healthcare Connections** 49 **UnitedHealthcare Community Plan** 280 **Humana Healthy Horizons** 29
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was	**Aetna Better Health of Louisiana** N/A **AmeriHealth Caritas Louisiana** N/A **Healthy Blue** N/A **Louisiana Healthcare Connections**

	actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	N/A **UnitedHealthcare Community Plan** N/A **Humana Healthy Horizons** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should	**Aetna Better Health of Louisiana** N/A **AmeriHealth Caritas Louisiana** N/A **Healthy Blue** N/A **Louisiana Healthcare Connections** N/A **UnitedHealthcare Community Plan** N/A **Humana Healthy Horizons** N/A

	first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Aetna Better Health of Louisiana** 426 **AmeriHealth Caritas Louisiana** 258 **Healthy Blue** 926 **Louisiana Healthcare Connections** 1,520 **UnitedHealthcare Community Plan** 1,690 **Humana Healthy Horizons** 316

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Louisiana** 7 **AmeriHealth Caritas Louisiana** 10 **Healthy Blue** 6 **Louisiana Healthcare Connections** 14 **UnitedHealthcare Community Plan** 73 **Humana Healthy Horizons** 3
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Louisiana** 211 **AmeriHealth Caritas Louisiana** 174 **Healthy Blue** 716 **Louisiana Healthcare Connections** 166 **UnitedHealthcare Community Plan** 598 **Humana Healthy Horizons** 162
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Louisiana** 1 **AmeriHealth Caritas Louisiana** 6 **Healthy Blue** 0 **Louisiana Healthcare Connections**

		10 **UnitedHealthcare Community Plan** 12 **Humana Healthy Horizons** 2
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Louisiana** 9 **AmeriHealth Caritas Louisiana** 17 **Healthy Blue** 1 **Louisiana Healthcare Connections** 10 **UnitedHealthcare Community Plan** 30 **Humana Healthy Horizons** 7
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Louisiana** 26 **AmeriHealth Caritas Louisiana** 14 **Healthy Blue** 51 **Louisiana Healthcare Connections** 17 **UnitedHealthcare Community Plan** 55 **Humana Healthy Horizons** 9
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan	**Aetna Better Health of Louisiana** 4 **AmeriHealth Caritas Louisiana** 0

	during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**Healthy Blue** 2 **Louisiana Healthcare Connections** 2 **UnitedHealthcare Community Plan** 4 **Humana Healthy Horizons** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**Aetna Better Health of Louisiana** N/A **AmeriHealth Caritas Louisiana** N/A **Healthy Blue** N/A **Louisiana Healthcare Connections** N/A **UnitedHealthcare Community Plan** N/A **Humana Healthy Horizons** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter “N/A”.	**Aetna Better Health of Louisiana** 71 **AmeriHealth Caritas Louisiana** 1 **Healthy Blue** 60 **Louisiana Healthcare Connections** 6 **UnitedHealthcare Community Plan** 34 **Humana Healthy Horizons** 16

D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter “N/A”.	**Aetna Better Health of Louisiana** 97 **AmeriHealth Caritas Louisiana** 51 **Healthy Blue** 91 **Louisiana Healthcare Connections** 1,295 **UnitedHealthcare Community Plan** 919 **Humana Healthy Horizons** 120
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter “N/A”.	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Aetna Better Health of Louisiana** 163 **AmeriHealth Caritas Louisiana** 54 **Healthy Blue** 138 **Louisiana Healthcare Connections** 120 **UnitedHealthcare Community Plan** 153 **Humana Healthy Horizons** 112
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Aetna Better Health of Louisiana** 22 **AmeriHealth Caritas Louisiana** 10 **Healthy Blue** 43 **Louisiana Healthcare Connections** 1,306 **UnitedHealthcare Community Plan** 282 **Humana Healthy Horizons** 16
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive	**Aetna Better Health of Louisiana** 112 **AmeriHealth Caritas Louisiana** 90 **Healthy Blue** 341 **Louisiana Healthcare Connections**

	travel or wait times, or other access issues.	65 **UnitedHealthcare Community Plan** 239 **Humana Healthy Horizons** 90
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Aetna Better Health of Louisiana** 49 **AmeriHealth Caritas Louisiana** 22 **Healthy Blue** 110 **Louisiana Healthcare Connections** 19 **UnitedHealthcare Community Plan** 738 **Humana Healthy Horizons** 85
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Aetna Better Health of Louisiana** 8 **AmeriHealth Caritas Louisiana** 3 **Healthy Blue** 5 **Louisiana Healthcare Connections** 1 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that	**Aetna Better Health of Louisiana** 61 **AmeriHealth Caritas Louisiana** 89

	were filed for a reason related to payment or billing issues.	**Healthy Blue** 289 **Louisiana Healthcare Connections** 8 **UnitedHealthcare Community Plan** 296 **Humana Healthy Horizons** 10
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Aetna Better Health of Louisiana** 8 **AmeriHealth Caritas Louisiana** 1 **Healthy Blue** 1 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 17 **Humana Healthy Horizons** 6

D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Aetna Better Health of Louisiana** 3 **AmeriHealth Caritas Louisiana** 4 **Healthy Blue** 0 **Louisiana Healthcare Connections** 1 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 1 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0

	longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Aetna Better Health of Louisiana** 0 **AmeriHealth Caritas Louisiana** 0 **Healthy Blue** 0 **Louisiana Healthcare Connections** 0 **UnitedHealthcare Community Plan** 0 **Humana Healthy Horizons** 0

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 91

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits: 3-11 years, 12-17 years, 18-21 years, Total

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Measure results

Aetna Better Health of Louisiana

3-11 years: 54.70%, 12-17 years: 50.85%, 18-21 years: 27.60%, Total: 48.72%

AmeriHealth Caritas Louisiana

3-11 years: 57.12%, 12-17 years: 53.65%, 18-21 years: 28.92%, Total: 51.04%

Healthy Blue

3-11 years: 55.27%, 12-17 years: 50.25%, 18-21 years: 26.05%, Total: 48.13%

Louisiana Healthcare Connections

3-11 years: 59.98%, 12-17 years: 56.83%, 18-21 years: 32.59%, Total: 54.23%

UnitedHealthcare Community Plan

3-11 years: 58.94%, 12-17 years: 56.04%, 18-21 years: 30.21%, Total: 2.93%

Humana Healthy Horizons

3-11 years: 50.03%, 12-17 years: 46.88%, 18-21 years: 22.23%, Total: 44.11%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life: First 15 Months 15 Months - 30 Months

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1392

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Measure results

Aetna Better Health of Louisiana

First 15 Months: 68.42% & 15 Months-30 Months: 70.22%

AmeriHealth Caritas Louisiana

First 15 Months: 65.05% & 15 Months-30 Months: 69.78%

Healthy Blue

First 15 Months: 62.83% & 15 Months-30 Months: 70.09%

Louisiana Healthcare Connections

First 15 Months: 63.17% & 15 Months-30 Months: 70.49%

UnitedHealthcare Community Plan

First 15 Months: 66.33% & 15 Months-30 Months: 69.64%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Adults' Access to Preventive/Ambulatory Health Services

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported: 20-44 years, 45-64 years, 65 years and older, Total

Measure results

Aetna Better Health of Louisiana

20-44 years: 67.99%, 45-64 years: 80.95%, 65 years and older: 68.44%, Total: 72.59%

AmeriHealth Caritas Louisiana

20-44 years: 68.12%, 45-64 years: 79.39%, 65 years and older: 76.08%, Total: 71.66%

Healthy Blue

20-44 years: 68.95%, 45-64 years: 78.32%, 65 years and older: 69.42%, Total: 71.81%

Louisiana Healthcare Connections

20-44 years: 76.80%, 45-64 years: 84.67%, 65 years and older: 82.46%, Total: 79.11%

UnitedHealthcare Community Plan

20-44 years: 75.53%, 45-64 years: 84.90%, 65 years and older: 74.54%, Total: 78.57%

Humana Healthy Horizons

20-44 years: 53.57%, 45-64 years: 57.41%, 65 years and older: 88.09%, Total: 55.59%

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

24

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity

Measure results

Aetna Better Health of Louisiana

BMI percentile documentation: 80.05%, Counseling for nutrition: 65.69%, Counseling for physical activity: 63.50%

AmeriHealth Caritas Louisiana

BMI percentile documentation: 75.37%, Counseling for nutrition: 64.39%, Counseling for physical activity: 62.20%

Healthy Blue

BMI percentile documentation: 76.89%, Counseling for nutrition: 64.23%, Counseling for physical activity: 59.61%

Louisiana Healthcare Connections

BMI percentile documentation: 81.51%, Counseling for nutrition: 70.56%, Counseling for physical activity: 59.12%

UnitedHealthcare Community Plan

BMI percentile documentation: 83.21%, Counseling for nutrition: 58.39%, Counseling for physical activity: 50.85%

Humana Healthy Horizons

BMI percentile documentation: 77.37%, Counseling for nutrition: 63.02%, Counseling for physical activity: 60.34%

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women Ages 16 to 24

5 / 91

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

33

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

Measure results

Aetna Better Health of Louisiana

Total: 64.55%

AmeriHealth Caritas Louisiana

Total: 64.32%

Healthy Blue

Total: 64.50%

Louisiana Healthcare Connections

Total: 67.37%

UnitedHealthcare Community Plan

Total: 65.49%

Humana Healthy Horizons

Total: 66.75%

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening

6 / 91

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

32

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage of women 21–64 years of age who were screened for cervical cancer: • Women 21-64 who had cervical cytology performed every 3 years. • Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years.

Measure results

Aetna Better Health of Louisiana

48.66%

AmeriHealth Caritas Louisiana

56.27%

Healthy Blue

50.61%

Louisiana Healthcare Connections

58.64%

UnitedHealthcare Community Plan

56.45%

Humana Healthy Horizons

30.17%

Complete

D2.VII.1 Measure Name: Hepatitis C Virus Screening

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage of eligible individuals screened for hepatitis C virus infection.

Measure results

Aetna Better Health of Louisiana

38.67%

AmeriHealth Caritas Louisiana

34.50%

Healthy Blue

38.14%

Louisiana Healthcare Connections

41.01%

UnitedHealthcare Community Plan

41.60%

Humana Healthy Horizons

29.26%

Complete

D2.VII.1 Measure Name: Developmental Screening in the First Three Years of Life

8 / 91

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1448

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Measure results

Aetna Better Health of Louisiana

52.49%

AmeriHealth Caritas Louisiana

50.39%

Healthy Blue

53.23%

Louisiana Healthcare Connections

44.58%

UnitedHealthcare Community Plan

50.04%

Humana Healthy Horizons

47.30%

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening

9 / 91

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0034

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer

Measure results

Aetna Better Health of Louisiana

43.21%

AmeriHealth Caritas Louisiana

44.95%

Healthy Blue

40.60%

Louisiana Healthcare Connections

44.28%

UnitedHealthcare Community Plan

43.82%

Humana Healthy Horizons

67.18%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21–44, LARC , 3 day rate

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 21-44 who had a live birth and were provided a most effective or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported.

Measure results

Aetna Better Health of Louisiana

2.45%

AmeriHealth Caritas Louisiana

1.69%

Healthy Blue

1.89%

Louisiana Healthcare Connections

1.72%

UnitedHealthcare Community Plan

1.24%

Humana Healthy Horizons

3.04%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21–44, LARC , 90 day rate

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported.

Measure results

Aetna Better Health of Louisiana

13.99%

AmeriHealth Caritas Louisiana

12.56%

Healthy Blue

12.65%

Louisiana Healthcare Connections

13.86%

UnitedHealthcare Community Plan

12.55%

Humana Healthy Horizons

13.35%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21–44, most or moderately effective, 3 day rate

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported.

Measure results

Aetna Better Health of Louisiana

10.35%

AmeriHealth Caritas Louisiana

11.11%

Healthy Blue

11.07%

Louisiana Healthcare Connections

10.88%

UnitedHealthcare Community Plan

10.65%

Humana Healthy Horizons

10.22%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21–44, most or moderately effective, 90 day rate

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported.

Measure results

Aetna Better Health of Louisiana

50.14%

AmeriHealth Caritas Louisiana

47.86%

Healthy Blue

47.05%

Louisiana Healthcare Connections

54.29%

UnitedHealthcare Community Plan

51.28%

Humana Healthy Horizons

45.40%

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 21–44, LARC

14 / 91

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2903/2904

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 21-44 who are at risk of unintended pregnancy and were provided a most or moderately effective method of contraception or were provided a LARC. Two rates are reported.

Measure results

Aetna Better Health of Louisiana

3.35%

AmeriHealth Caritas Louisiana

3.13%

Healthy Blue

3.12%

Louisiana Healthcare Connections

3.41%

UnitedHealthcare Community Plan

3.29%

Humana Healthy Horizons

2.36%

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 21–44, most or moderately effective

15 / 91

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2903/2904

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 21-44 who are at risk of unintended pregnancy and were provided a most or moderately effective method of contraception or were provided a LARC. Two rates are reported.

Measure results

Aetna Better Health of Louisiana

23.41%

AmeriHealth Caritas Louisiana

24.60%

Healthy Blue

23.39%

Louisiana Healthcare Connections

26.58%

UnitedHealthcare Community Plan

26.06%

Humana Healthy Horizons

18.05%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

Measure results

Aetna Better Health of Louisiana

81.02%

AmeriHealth Caritas Louisiana

80.33%

Healthy Blue

82.97%

Louisiana Healthcare Connections

78.83%

UnitedHealthcare Community Plan

87.59%

Humana Healthy Horizons

80.05%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum Care

17 / 91

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1717

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.

Measure results

Aetna Better Health of Louisiana

77.37%

AmeriHealth Caritas Louisiana

73.77%

Healthy Blue

78.59%

Louisiana Healthcare Connections

77.62%

UnitedHealthcare Community Plan

77.37%

Humana Healthy Horizons

76.64%

Complete

D2.VII.1 Measure Name: Cesarean Rate for Low-Risk First Birth Women

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).

Measure results

Aetna Better Health of Louisiana

27.93% (*A lower rate is desirable)

AmeriHealth Caritas Louisiana

25.06% (*A lower rate is desirable)

Healthy Blue

26.32% (*A lower rate is desirable)

Louisiana Healthcare Connections

27.18% (*A lower rate is desirable)

UnitedHealthcare Community Plan

26.41% (*A lower rate is desirable)

Humana Healthy Horizons

23.54% (*A lower rate is desirable)

Complete

D2.VII.1 Measure Name: Percentage of Low Birth Weight Births

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1382

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage of live births that weighted less than 2,500 grams in the state during the reporting period.

Measure results

Aetna Better Health of Louisiana

11.74%

AmeriHealth Caritas Louisiana

12.62%

Healthy Blue

13.53%

Louisiana Healthcare Connections

12.97%

UnitedHealthcare Community Plan

12.07%

Humana Healthy Horizons

11.46%

Complete

D2.VII.1 Measure Name: Asthma in Younger Adults Admission Rate

20 / 91

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

283

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.

Measure results

Aetna Better Health of Louisiana

1.75 (* A lower rate desirable)

AmeriHealth Caritas Louisiana

1.29 (* A lower rate desirable)

Healthy Blue

2.13 (* A lower rate desirable)

Louisiana Healthcare Connections

1.87 (* A lower rate desirable)

UnitedHealthcare Community Plan

2.45 (* A lower rate desirable)

Humana Healthy Horizons

0.18 (* A lower rate desirable)

Complete

D2.VII.1 Measure Name: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

275

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older.

Measure results

Aetna Better Health of Louisiana

16.24 (* A lower rate is desirable)

AmeriHealth Caritas Louisiana

22.60 (* A lower rate is desirable)

Healthy Blue

13.73 (* A lower rate is desirable)

Louisiana Healthcare Connections

21.49 (* A lower rate is desirable)

UnitedHealthcare Community Plan

17.80 (* A lower rate is desirable)

Humana Healthy Horizons

7.05 (* A lower rate is desirable)

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression

22 / 91

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

2082/3210e

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200.

Measure results

Aetna Better Health of Louisiana

85.13%

AmeriHealth Caritas Louisiana

80.81%

Healthy Blue

83.48%

Louisiana Healthcare Connections

81.99%

UnitedHealthcare Community Plan

82.05%

Humana Healthy Horizons

73.46%

Complete

D2.VII.1 Measure Name: Heart Failure Admission Rate

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0277

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish).

Measure results

Aetna Better Health of Louisiana

28.24 (* A lower rate is desirable)

AmeriHealth Caritas Louisiana

29.72 (* A lower rate is desirable)

Healthy Blue

21.12 (* A lower rate is desirable)

Louisiana Healthcare Connections

26.20 (* A lower rate is desirable)

UnitedHealthcare Community Plan

26.72 (* A lower rate is desirable)

Humana Healthy Horizons

13.77 (* A lower rate is desirable)

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0018

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Measure results

Aetna Better Health of Louisiana

63.26%

AmeriHealth Caritas Louisiana

60.80%

Healthy Blue

56.93%

Louisiana Healthcare Connections

60.34%

UnitedHealthcare Community Plan

61.80%

Humana Healthy Horizons

69.10%

Complete

D2.VII.1 Measure Name: Diabetes Short-Term Complications Admission Rate

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0272

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older.

Measure results

Aetna Better Health of Louisiana

13.08 (* A lower rate is desirable)

AmeriHealth Caritas Louisiana

19.87 (* A lower rate is desirable)

Healthy Blue

13.33 (* A lower rate is desirable)

Louisiana Healthcare Connections

20.01 (* A lower rate is desirable)

UnitedHealthcare Community Plan

17.12 (* A lower rate is desirable)

Humana Healthy Horizons

8.26 (* A lower rate is desirable)

Complete

D2.VII.1 Measure Name: Ambulatory Care: Emergency Department Visits/1000 MY

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure summarizes utilization of ambulatory care ED Visits per 1,000 member years.

Measure results

Aetna Better Health of Louisiana

774.29 (* A lower rate is desirable)

AmeriHealth Caritas Louisiana

732.55 (* A lower rate is desirable)

Healthy Blue

729.1 (* A lower rate is desirable)

Louisiana Healthcare Connections

762.05 (* A lower rate is desirable)

UnitedHealthcare Community Plan

758.06 (* A lower rate is desirable)

Humana Healthy Horizons

559.12 (* A lower rate is desirable)

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care: HbA1c control (less-than 8.0%) 27 / 91

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: •HbA1c control (less-than 8.0%)

Measure results

Aetna Better Health of Louisiana

59.61%

AmeriHealth Caritas Louisiana

59.61%

Healthy Blue

62.29%

Louisiana Healthcare Connections

61.56%

UnitedHealthcare Community Plan

70.07%

Humana Healthy Horizons

66.91%

Complete

D2.VII.1 Measure Name: Eye Exam for Patients With Diabetes

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) with an eye exam (retinal) performed. exam

Measure results

Aetna Better Health of Louisiana

46.96%

AmeriHealth Caritas Louisiana

51.09%

Healthy Blue

55.47%

Louisiana Healthcare Connections

59.37%

UnitedHealthcare Community Plan

54.74%

Humana Healthy Horizons

54.74%

Complete

D2.VII.1 Measure Name: Blood Pressure Control for Patients With Diabetes (less-than 140/90 mm Hg)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with BP control (less-than 140/90 mm Hg)

Measure results

Aetna Better Health of Louisiana

62.29%

AmeriHealth Caritas Louisiana

64.48%

Healthy Blue

63.50%

Louisiana Healthcare Connections

63.02%

UnitedHealthcare Community Plan

70.07%

Humana Healthy Horizons

71.78%

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients With Diabetes: HbA1c poor control (>9.0%)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c poor control (>9.0%)

Measure results

Aetna Better Health of Louisiana

33.33%

AmeriHealth Caritas Louisiana

33.09%

Healthy Blue

30.66%

Louisiana Healthcare Connections

31.63%

UnitedHealthcare Community Plan

23.60%

Humana Healthy Horizons

27.25%

Complete

D2.VII.1 Measure Name: Statin Therapy for Patients with Cardiovascular Disease: Received Statin Therapy: Total

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy (were dispensed at least one high or moderate-intensity statin medication during the measurement year.)

Measure results

Aetna Better Health of Louisiana

82.75%

AmeriHealth Caritas Louisiana

83.76%

Healthy Blue

83.00%

Louisiana Healthcare Connections

81.94%

UnitedHealthcare Community Plan

82.82%

Humana Healthy Horizons

83.02%

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions: Observed Readmission

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1768

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

For members 18 -64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Measure results

Aetna Better Health of Louisiana

11.18%

AmeriHealth Caritas Louisiana

10.73%

Healthy Blue

9.32%

Louisiana Healthcare Connections

10.06%

UnitedHealthcare Community Plan

10.37%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions: Expected Readmissions Rate

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1768

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

For members 18 -64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Measure results

Aetna Better Health of Louisiana

10.38%

AmeriHealth Caritas Louisiana

10.04%

Healthy Blue

9.40%

Louisiana Healthcare Connections

9.62%

UnitedHealthcare Community Plan

10.00%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions: Observed-to-Expected Ratio (Observed Readmission/Expected Readmissions)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1768

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

For members 18 -64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Measure results

Aetna Better Health of Louisiana

1.0778

AmeriHealth Caritas Louisiana

1.0691

Healthy Blue

0.9911

Louisiana Healthcare Connections

1.046

UnitedHealthcare Community Plan

1.0376

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Disorder Treatment: Initiation of SUD Treatment.

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement: Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.

Measure results

Aetna Better Health of Louisiana

61.26%

AmeriHealth Caritas Louisiana

65.10%

Healthy Blue

58.91%

Louisiana Healthcare Connections

49.81%

UnitedHealthcare Community Plan

60.16%

Humana Healthy Horizons

59.40%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Disorder Treatment: Engagement of SUD

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement: Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Measure results

Aetna Better Health of Louisiana

26.94%

AmeriHealth Caritas Louisiana

30.10%

Healthy Blue

25.02%

Louisiana Healthcare Connections

15.87%

UnitedHealthcare Community Plan

28.17%

Humana Healthy Horizons

26.91%

Complete

D2.VII.1 Measure Name: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0027

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Advising Smokers and Tobacco Users to Quit

Measure results

Aetna Better Health of Louisiana

74.60%

AmeriHealth Caritas Louisiana

77.05%

Healthy Blue

75.00%

Louisiana Healthcare Connections

71.81%

UnitedHealthcare Community Plan

66.07%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0027

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Discussing Cessation Medications

Measure results

Aetna Better Health of Louisiana

55.91%

AmeriHealth Caritas Louisiana

55.06%

Healthy Blue

50.00%

Louisiana Healthcare Connections

45.10%

UnitedHealthcare Community Plan

51.82%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0027

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Discussing Cessation Strategies

Measure results

Aetna Better Health of Louisiana

52.00%

AmeriHealth Caritas Louisiana

53.37%

Healthy Blue

48.28%

Louisiana Healthcare Connections

42.48%

UnitedHealthcare Community Plan

48.15%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management: Effective Acute Phase Treatment

40 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. Effective Acute Phase Treatment

Measure results

Aetna Better Health of Louisiana

61.92%

AmeriHealth Caritas Louisiana

56.31%

Healthy Blue

55.53%

Louisiana Healthcare Connections

59.73%

UnitedHealthcare Community Plan

55.90%

Humana Healthy Horizons

72.53%

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management : Effective Continuation Phase Treatment

41 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. Effective Continuation Phase Treatment

Measure results

Aetna Better Health of Louisiana

46.12%

AmeriHealth Caritas Louisiana

38.89%

Healthy Blue

37.60%

Louisiana Healthcare Connections

42.60%

UnitedHealthcare Community Plan

36.41%

Humana Healthy Horizons

61.54%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness:

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge.

Measure results

Aetna Better Health of Louisiana

37.03%

AmeriHealth Caritas Louisiana

38.49%

Healthy Blue

41.13%

Louisiana Healthcare Connections

41.60%

UnitedHealthcare Community Plan

39.16%

Humana Healthy Horizons

32.48%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the member received follow-up within 7 days after discharge.

Measure results

Aetna Better Health of Louisiana

18.61%

AmeriHealth Caritas Louisiana

19.82%

Healthy Blue

23.27%

Louisiana Healthcare Connections

20.70%

UnitedHealthcare Community Plan

20.73%

Humana Healthy Horizons

15.12%

Complete

D2.VII.1 Measure Name: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

44 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1932

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Measure results

Aetna Better Health of Louisiana

85.69%

AmeriHealth Caritas Louisiana

84.73%

Healthy Blue

84.08%

Louisiana Healthcare Connections

83.89%

UnitedHealthcare Community Plan

83.96%

Humana Healthy Horizons

92.86%

Complete

D2.VII.1 Measure Name: Pharmacotherapy for Opioid Use Disorder

45 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3400

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of new opioid use disorder (OUD) pharmacotherapy episodes that resulted in 180 or more covered treatment days among members 16 years of age and older with a diagnosis of OUD

Measure results

Aetna Better Health of Louisiana

38.41%

AmeriHealth Caritas Louisiana

34.07%

Healthy Blue

24.55%

Louisiana Healthcare Connections

34.11%

UnitedHealthcare Community Plan

21.85%

Humana Healthy Horizons

61.18%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication: Initiation Phase.

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. - Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. - Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Measure results

Aetna Better Health of Louisiana

43.17%

AmeriHealth Caritas Louisiana

49.75%

Healthy Blue

45.21%

Louisiana Healthcare Connections

44.21%

UnitedHealthcare Community Plan

46.24%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication: Continuation and Maintenance (C&M) Phase

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. - Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day

Initiation Phase. - Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended

Measure results

Aetna Better Health of Louisiana

63.39%

AmeriHealth Caritas Louisiana

56.83%

Healthy Blue

53.66%

Louisiana Healthcare Connections

51.43%

UnitedHealthcare Community Plan

58.55%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

48 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2801

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Measure results

Aetna Better Health of Louisiana

68.80%

AmeriHealth Caritas Louisiana

56.83%

Healthy Blue

64.93%

Louisiana Healthcare Connections

61.74%

UnitedHealthcare Community Plan

65.02%

Humana Healthy Horizons

67.65%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

Measure results

Aetna Better Health of Louisiana

33.39%

AmeriHealth Caritas Louisiana

31.59%

Healthy Blue

41.69%

Louisiana Healthcare Connections

38.24%

UnitedHealthcare Community Plan

37.68%

Humana Healthy Horizons

22.35%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Measure results

Aetna Better Health of Louisiana

20.76%

AmeriHealth Caritas Louisiana

20.59%

Healthy Blue

24.63%

Louisiana Healthcare Connections

22.39%

UnitedHealthcare Community Plan

22.84%

Humana Healthy Horizons

15.15%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

Measure results

Aetna Better Health of Louisiana

24.59%

AmeriHealth Caritas Louisiana

20.50%

Healthy Blue

21.45%

Louisiana Healthcare Connections

21.89%

UnitedHealthcare Community Plan

22.92%

Humana Healthy Horizons

14.86%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use

52 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Measure results

Aetna Better Health of Louisiana

15.38%

AmeriHealth Caritas Louisiana

12.51%

Healthy Blue

13.28%

Louisiana Healthcare Connections

13.42%

UnitedHealthcare Community Plan

14.40%

Humana Healthy Horizons

8.95%

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

53 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Measure results

Aetna Better Health of Louisiana

58.31%

AmeriHealth Caritas Louisiana

57.23%

Healthy Blue

50.89%

Louisiana Healthcare Connections

60.69%

UnitedHealthcare Community Plan

51.27%

Humana Healthy Horizons

64.55%

Complete

D2.VII.1 Measure Name: Diabetes Monitoring for People with Diabetes and Schizophrenia

54 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Measure results

Aetna Better Health of Louisiana

70.70%

AmeriHealth Caritas Louisiana

71.29%

Healthy Blue

72.14%

Louisiana Healthcare Connections

73.32%

UnitedHealthcare Community Plan

72.74%

Humana Healthy Horizons

70.69%

Complete

D2.VII.1 Measure Name: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

55 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.

Measure results

Aetna Better Health of Louisiana

83.33%

AmeriHealth Caritas Louisiana

80.00%

Healthy Blue

79.75%

Louisiana Healthcare Connections

81.91%

UnitedHealthcare Community Plan

82.43%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year. Blood Glucose Testing

Measure results

Aetna Better Health of Louisiana

60.00%

AmeriHealth Caritas Louisiana

54.61%

Healthy Blue

57.96%

Louisiana Healthcare Connections

52.36%

UnitedHealthcare Community Plan

55.96%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year. Cholesterol Testing

Measure results

Aetna Better Health of Louisiana

30.00%

AmeriHealth Caritas Louisiana

25.00%

Healthy Blue

31.27%

Louisiana Healthcare Connections

25.93%

UnitedHealthcare Community Plan

30.19%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics

58 / 91

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year. Blood Glucose and Cholesterol Testing

Measure results

Aetna Better Health of Louisiana

29.38%

AmeriHealth Caritas Louisiana

24.42%

Healthy Blue

30.48%

Louisiana Healthcare Connections

24.86%

UnitedHealthcare Community Plan

29.38%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Appropriate Treatment for Children with Upper Respiratory Infection

59 / 91

D2.VII.2 Measure Domain

Low Value Care

D2.VII.3 National Quality Forum (NQF) number

0069

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Measure results

Aetna Better Health of Louisiana

79.68%

AmeriHealth Caritas Louisiana

80.40%

Healthy Blue

80.11%

Louisiana Healthcare Connections

80.12%

UnitedHealthcare Community Plan

80.14%

Humana Healthy Horizons

99.68%

Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

60 / 91

D2.VII.2 Measure Domain

Low Value Care

D2.VII.3 National Quality Forum (NQF) number

0058

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Measure results

Aetna Better Health of Louisiana

50.75%

AmeriHealth Caritas Louisiana

54.77%

Healthy Blue

52.78%

Louisiana Healthcare Connections

51.12%

UnitedHealthcare Community Plan

48.99%

Humana Healthy Horizons

98.14%

Complete

D2.VII.1 Measure Name: Non-recommended Cervical Screening in Adolescent Females

61 / 91

D2.VII.2 Measure Domain

Low Value Care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. Note: A lower rate indicates

better performance.

Measure results

Aetna Better Health of Louisiana

0.50%

AmeriHealth Caritas Louisiana

2.45%

Healthy Blue

0.67%

Louisiana Healthcare Connections

2.05%

UnitedHealthcare Community Plan

2.51%

Humana Healthy Horizons

1.33%

Complete

D2.VII.1 Measure Name: Use of Imaging Studies for Low Back Pain

62 / 91

D2.VII.2 Measure Domain

Low Value Care

D2.VII.3 National Quality Forum (NQF) number

0052

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Measure results

Aetna Better Health of Louisiana

67.96%

AmeriHealth Caritas Louisiana

69.88%

Healthy Blue

69.31%

Louisiana Healthcare Connections

69.11%

UnitedHealthcare Community Plan

69.60%

Humana Healthy Horizons

70.31%

Complete

D2.VII.1 Measure Name: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid)

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

6

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.

Measure results

Aetna Better Health of Louisiana

72.73%

AmeriHealth Caritas Louisiana

76.47%

Healthy Blue

75.25%

Louisiana Healthcare Connections

78.67%

UnitedHealthcare Community Plan

82.95%

Humana Healthy Horizons

73.50%

Complete

D2.VII.1 Measure Name: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version (Medicaid)

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

6

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure provides information on parents' experience with their child's Medicaid organization.

Measure results

Aetna Better Health of Louisiana

83.26%

AmeriHealth Caritas Louisiana

85.96%

Healthy Blue

89.36%

Louisiana Healthcare Connections

90.40%

UnitedHealthcare Community Plan

91.02%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data"

65 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good health. Adult- Very Good

Measure results

Aetna Better Health of Louisiana

21.64%

AmeriHealth Caritas Louisiana

22.06%

Healthy Blue

23.65%

Louisiana Healthcare Connections

24.23%

UnitedHealthcare Community Plan

19.21%

Humana Healthy Horizons

19.51%

Complete

D2.VII.1 Measure Name: Self-Reported Overall Mental or Emotional Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data.

66 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good health. Adult - Excellent

Measure results

Aetna Better Health of Louisiana

12.28%

AmeriHealth Caritas Louisiana

9.80%

Healthy Blue

13.79%

Louisiana Healthcare Connections

10.13%

UnitedHealthcare Community Plan

14.69%

Humana Healthy Horizons

17.07%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data"

67 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good health. Child General - Very Good

Measure results

Aetna Better Health of Louisiana

34.87%

AmeriHealth Caritas Louisiana

33.71%

Healthy Blue

34.32%

Louisiana Healthcare Connections

39.33%

UnitedHealthcare Community Plan

33.53%

Humana Healthy Horizons

27.54%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data"

68 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good health. Child General - Excellent

Measure results

Aetna Better Health of Louisiana

40.88%

AmeriHealth Caritas Louisiana

44.38%

Healthy Blue

46.61%

Louisiana Healthcare Connections

35.39%

UnitedHealthcare Community Plan

40.72%

Humana Healthy Horizons

44.93%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data"

69 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good health. Child CCC - Very Good

Measure results

Aetna Better Health of Louisiana

36.62%

AmeriHealth Caritas Louisiana

33.81%

Healthy Blue

36.90%

Louisiana Healthcare Connections

38.39%

UnitedHealthcare Community Plan

30.10%

Humana Healthy Horizons

36.92%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data

70 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good health. Child CCC - Excellent

Measure results

Aetna Better Health of Louisiana

22.54%

AmeriHealth Caritas Louisiana

17.99%

Healthy Blue

23.99%

Louisiana Healthcare Connections

20.85%

UnitedHealthcare Community Plan

25.24%

Humana Healthy Horizons

18.46%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Mental or Emotional Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data." 71 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good mental or emotional health. Adult - Very Good

Measure results

Aetna Better Health of Louisiana

20.93%

AmeriHealth Caritas Louisiana

14.50%

Healthy Blue

23.15%

Louisiana Healthcare Connections

19.38%

UnitedHealthcare Community Plan

18.08%

Humana Healthy Horizons

13.11%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Mental or Emotional Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data." 72 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good mental or emotional health. Adult - Excellent

Measure results

Aetna Better Health of Louisiana

14.53%

AmeriHealth Caritas Louisiana

22.00%

Healthy Blue

17.73%

Louisiana Healthcare Connections

18.94%

UnitedHealthcare Community Plan

19.77%

Humana Healthy Horizons

22.95%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Mental or Emotional Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data." 73 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good mental or emotional health. Child General - Very Good

Measure results

Aetna Better Health of Louisiana

24.02%

AmeriHealth Caritas Louisiana

23.89%

Healthy Blue

24.47%

Louisiana Healthcare Connections

24.43%

UnitedHealthcare Community Plan

25.90%

Humana Healthy Horizons

21.74%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Mental or Emotional Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data." 74 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good mental or emotional health. Child General - Excellent

Measure results

Aetna Better Health of Louisiana

48.50%

AmeriHealth Caritas Louisiana

47.22%

Healthy Blue

48.10%

Louisiana Healthcare Connections

38.64%

UnitedHealthcare Community Plan

43.98%

Humana Healthy Horizons

53.62%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Mental or Emotional Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data." 75 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good mental or emotional health. Child CCC - Very Good

Measure results

Aetna Better Health of Louisiana

25.26%

AmeriHealth Caritas Louisiana

24.29%

Healthy Blue

28.04%

Louisiana Healthcare Connections

18.87%

UnitedHealthcare Community Plan

21.08%

Humana Healthy Horizons

19.70%

Complete

D2.VII.1 Measure Name: "Self-Reported Overall Mental or Emotional Health (Adult and Child) Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data." 76 / 91

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members reporting overall excellent or very good mental or emotional health. Child CCC - Excellent

Measure results

Aetna Better Health of Louisiana

18.60%

AmeriHealth Caritas Louisiana

14.29%

Healthy Blue

18.45%

Louisiana Healthcare Connections

15.57%

UnitedHealthcare Community Plan

19.12%

Humana Healthy Horizons

19.70%

Complete

D2.VII.1 Measure Name: Lead Screening in Children

77 / 91

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Measure results

Aetna Better Health of Louisiana

67.64%

AmeriHealth Caritas Louisiana

69.83%

Healthy Blue

64.73%

Louisiana Healthcare Connections

68.13%

UnitedHealthcare Community Plan

64.24%

Humana Healthy Horizons

43.59%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status

78 / 91

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Measure results

Aetna Better Health of Louisiana

63.02%

AmeriHealth Caritas Louisiana

64.95%

Healthy Blue

67.88%

Louisiana Healthcare Connections

63.80%

UnitedHealthcare Community Plan

65.94%

Humana Healthy Horizons

51.60%

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 15 - 20: LARC

79 / 91

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

#2903/2904

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 15-20 who are at risk of unintended pregnancy and were provided a most or moderately effective method of contraception or were provided a LARC. Two rates are reported. - Contraceptive Care-All Women Ages 15–20, LARC -Contraceptive Care-All Women Ages 15–20, most or moderately effective

Measure results

Aetna Better Health of Louisiana

3.24%

AmeriHealth Caritas Louisiana

2.92%

Healthy Blue

3.42%

Louisiana Healthcare Connections

2.74%

UnitedHealthcare Community Plan

3.05%

Humana Healthy Horizons

2.18%

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 15 - 20: Most or moderately effective

80 / 91

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

#2903 / 2904

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 15-20 who are at risk of unintended pregnancy and were provided a most or moderately effective method of contraception or were provided a LARC. Two rates are reported. - Contraceptive Care-All Women Ages 15–20, LARC - Contraceptive Care-All Women Ages 15–20, most or moderately effective

Measure results

Aetna Better Health of Louisiana

26.21%

AmeriHealth Caritas Louisiana

27.63%

Healthy Blue

28.86%

Louisiana Healthcare Connections

29.38%

UnitedHealthcare Community Plan

29.54%

Humana Healthy Horizons

19.38%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 15-20: LARC, 3 day rate

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported. -Contraceptive Care – Postpartum Ages 15–20, LARC, 3 day rate -Contraceptive Care – Postpartum Ages 15–20,

LARC, 90 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 3 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 90 day rate

Measure results

Aetna Better Health of Louisiana

6.35%

AmeriHealth Caritas Louisiana

2.84%

Healthy Blue

3.57%

Louisiana Healthcare Connections

2.42%

UnitedHealthcare Community Plan

1.82%

Humana Healthy Horizons

4.15%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Ages 15–20, LARC, 90 day rate

82 / 91

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported. - -Contraceptive Care – Postpartum Ages 15–20, LARC, 3 day rate -Contraceptive Care – Postpartum Ages 15–20, LARC, 90 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 3 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 90 day rate

Measure results

Aetna Better Health of Louisiana

19.26%

AmeriHealth Caritas Louisiana

13.88%

Healthy Blue

16.74%

Louisiana Healthcare Connections

16.12%

UnitedHealthcare Community Plan

15.15%

Humana Healthy Horizons

20.73%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 3 day rate

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported. - -Contraceptive Care – Postpartum Ages 15–20, LARC, 3 day rate -Contraceptive Care – Postpartum Ages 15–20, LARC, 90 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 3 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 90 day rate

Measure results

Aetna Better Health of Louisiana

8.66%

AmeriHealth Caritas Louisiana

5.36%

Healthy Blue

5.36%

Louisiana Healthcare Connections

5.82%

UnitedHealthcare Community Plan

2.55%

Humana Healthy Horizons

6.22%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 90 day rate

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported. - -Contraceptive Care – Postpartum Ages 15–20, LARC, 3 day rate -Contraceptive Care – Postpartum Ages 15–20, LARC, 90 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 3 day rate -Contraceptive Care – Postpartum Ages 15–20, most or moderately effective, 90 day rate

Measure results

Aetna Better Health of Louisiana

47.37%

AmeriHealth Caritas Louisiana

51.10%

Healthy Blue

48.88%

Louisiana Healthcare Connections

59.15%

UnitedHealthcare Community Plan

55.29%

Humana Healthy Horizons

50.78%

Complete

D2.VII.1 Measure Name: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Child Version (Medicaid) (Rating of Health Plan-CCC, 8+9+10)

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

6

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure provides information on parent's experience with their child's Medicaid organization for the population of children with chronic conditions.

Measure results

Aetna Better Health of Louisiana

81.27%

AmeriHealth Caritas Louisiana

83.45%

Healthy Blue

86.62%

Louisiana Healthcare Connections

83.89%

UnitedHealthcare Community Plan

86.89%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Topical Fluoride for Children

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

3701

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 1-4 years of age who received at least two fluoride varnish applications during the measurement year. Report two age stratifications and a total rate: • 1-2 years • 3-4 years • Total

Measure results

Aetna Better Health of Louisiana

1-2 years: 1.42%, 3-4 years: 0.64%, & Total: 1.00%

AmeriHealth Caritas Louisiana

1-2 years: 6.32%, 3-4 years: 9.66%, & Total: 7.97%

Healthy Blue

1-2 years: 5.60%, 3-4 years: 7.93%, & Total: 6.79%

Louisiana Healthcare Connections

1-2 years: 6.54%, 3-4 years: 10.52%, Total: 8.55%

UnitedHealthcare Community Plan

1-2 years: 2.24%, 3-4 years: 0.93%, & Total: 1.56%

Humana Healthy Horizons

1-2 years: 2.27%, 3-4 years: 0.88%, & Total: 1.50%

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Ages 5-64 as of December 31 of the measurement year. • Total

Measure results

Aetna Better Health of Louisiana

79.36%

AmeriHealth Caritas Louisiana

73.49%

Healthy Blue

77.55%

Louisiana Healthcare Connections

74.21%

UnitedHealthcare Community Plan

60.16%

Humana Healthy Horizons

NA

Complete

D2.VII.1 Measure Name: Inpatient Utilization—General Hospital/Acute Care: Maternity

D2.VII.2 Measure Domain

Utilization Measure

D2.VII.3 National Quality Forum (NQF) number

NA

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure summarizes utilization of acute inpatient care and services in the following categories: • Maternity • Surgery • Medicine • Total Inpatient

Measure results

Aetna Better Health of Louisiana

Maternity - Days/1,000 Member Years: 65.55, Discharges/1,000 Member Years: 23.48, Average Length of Stay: 2.79

AmeriHealth Caritas Louisiana

Maternity - Days/1,000 Member Years: 80.47, Discharges/1,000 Member Years: 28.68, Average Length of Stay: 2.81

Healthy Blue

Maternity - Days/1,000 Member Years: 85.16, Discharges/1,000 Member Years: 31.1, Average Length of Stay: 2.74

Louisiana Healthcare Connections

Maternity - Days/1,000 Member Years: 88.82, Discharges/1,000 Member Years: 32.5, Average Length of Stay: 2.73

UnitedHealthcare Community Plan

Not required

Humana Healthy Horizons

Maternity - Days/1,000 Member Years: 76.06, Discharges/1,000 Member Years: 28.18, Average Length of Stay: 2.7

Complete

D2.VII.1 Measure Name: Inpatient Utilization—General Hospital/Acute Care: Medicine

D2.VII.2 Measure Domain

Utilization Measure

D2.VII.3 National Quality Forum (NQF) number

NA

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure summarizes utilization of acute inpatient care and services in the following categories: • Maternity • Surgery • Medicine • Total Inpatient

Measure results

Aetna Better Health of Louisiana

Medicine - Days/1,000 Member Years: 142.36, Medicine - Discharges/1,000 Member Years: 26.11, Medicine - Average Length of Stay: 5.45

AmeriHealth Caritas Louisiana

Medicine - Days/1,000 Member Years: 137.61, Medicine - Discharges/1,000 Member Years: 28.34, Medicine - Average Length of Stay: 4.86

Healthy Blue

Medicine - Days/1,000 Member Years: 132.55, Medicine - Discharges/1,000 Member Years: 26.52, Medicine - Average Length of Stay: 5

Louisiana Healthcare Connections

Medicine - Days/1,000 Member Years: 129.83, Medicine - Discharges/1,000 Member Years: 28.47, Medicine - Average Length

of Stay: 4.56

UnitedHealthcare Community Plan

Not Required

Humana Healthy Horizons

Medicine - Days/1,000 Member Years: 99.99, Medicine - Discharges/1,000 Member Years: 19.72, Medicine - Average Length of Stay: 5.07

Complete

D2.VII.1 Measure Name: 3. Inpatient Utilization—General Hospital/Acute Care: Surgery

D2.VII.2 Measure Domain

Utilization Measure

D2.VII.3 National Quality Forum (NQF) number

NA

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure summarizes utilization of acute inpatient care and services in the following categories: • Maternity • Surgery • Medicine • Total Inpatient

Measure results

Aetna Better Health of Louisiana

Surgery - Days/1,000 Member Years: 154, Surgery - Discharges/1,000 Member Years: 16.89, Surgery - Average Length of Stay: 9.12

AmeriHealth Caritas Louisiana

Surgery - Days/1,000 Member Years: 112.99, Surgery - Discharges/1,000 Member Years: 13.48, Surgery - Average Length of Stay: 8.38

Healthy Blue

Surgery - Days/1,000 Member Years: 27.42, Surgery - Discharges/1,000 Member Years: 15.5, Surgery - Average Length of Stay: 8.22

Louisiana Healthcare Connections

Surgery - Days/1,000 Member Years: 124.12, Surgery - Discharges/1,000 Member Years: 14.23, Surgery - Average Length of Stay: 8.72

UnitedHealthcare Community Plan

Not Required

Humana Healthy Horizons

Surgery - Days/1,000 Member Years: 95.8, Surgery - Discharges/1,000 Member Years: 11.42, Surgery - Average Length of Stay: 8.39

Complete

D2.VII.1 Measure Name: Inpatient Utilization—General Hospital/Acute Care: Total

91 / 91

D2.VII.2 Measure Domain

Utilization Measure

D2.VII.3 National Quality Forum (NQF) number

NA

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure summarizes utilization of acute inpatient care and services in the following categories: • Maternity • Surgery • Medicine • Total Inpatient

Measure results

Aetna Better Health of Louisiana

Total inpatient - Days/1,000 Member Years: 348.13, Discharges/1,000 Member Years: 61.55, Total inpatient - Average Length of Stay: 5.66

AmeriHealth Caritas Louisiana

Total inpatient - Days/1,000 Member Years: 309.98, Total inpatient - Discharges/1,000 Member Years: 62.98, Total inpatient - Average Length of Stay: 4.92

Healthy Blue

Total inpatient - Days/1,000 Member Years: 327.43, Total inpatient - Discharges/1,000 Member Years: 66.65, Total inpatient - Average Length of Stay: 4.91

Louisiana Healthcare Connections

Total inpatient - Days/1,000 Member Years: 318.35, Total inpatient - Discharges/1,000 Member Years: 66.27, Total inpatient - Average Length of Stay: 4.8

UnitedHealthcare Community Plan

Not Required

Humana Healthy Horizons

Total inpatient - Days/1,000 Member Years: 250.83, Total inpatient - Discharges/1,000 Member Years: 51.53, Total inpatient - Average Length of Stay: 4.87

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 110

Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Aetna Better Health of Louisiana

D3.VIII.4 Reason for intervention

Provider Network

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

02/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

2 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Aetna Better Health of Louisiana

D3.VIII.4 Reason for intervention

Quality Management

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

01/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 05/01/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

3 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Aetna Better Health of Louisiana

D3.VIII.4 Reason for intervention

Services and Benefits

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/29/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

4 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Aetna Better Health of Louisiana

D3.VIII.4 Reason for intervention

Services and Benefits

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

10/24/2024

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

5 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Aetna Better Health of Louisiana

D3.VIII.4 Reason for intervention

Services and Benefits-Failure to reprocess claims timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/13/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 07/11/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Provider Network] Failure to validate provider directory data and maintain an accuracy rate of improvement.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

02/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/07/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

7 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

02/08/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

8 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Claims and Encounter Management] Failure to Adhere to LDH Directives on Pharmacy Co-Pays and Supply Limits

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

09/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

9 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 02/12/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

10 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to meet case management requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

11 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to meet prompt pay performance standards

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

09/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

12 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/14/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

13 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees timely

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

09/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

14 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$2,500

D3.VIII.7 Date assessed

09/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

15 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 02/14/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

16 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to meet case management requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

17 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to adhere to LDH directive to implement a rate change and reprocess claims

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

18 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Enrollee Services] Failure to process member grievances and appeals timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/19/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

19 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

AmeriHealth Caritas Louisiana

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit complete and accurate reports timely

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
n/a

D3.VIII.7 Date assessed
09/25/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

20 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
Healthy Blue

D3.VIII.4 Reason for intervention

[Provider Network] Failure to validate provider directory data and maintain an accuracy rate and improvement.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$50,000

D3.VIII.7 Date assessed
02/15/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance letter

21 / 110

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
Healthy Blue

Performance improvement

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

n/a

D3.VIII.7 Date assessed

01/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 02/12/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

22 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to load provider data and correct inappropriate claim denials timely

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$145,000

D3.VIII.7 Date assessed

01/25/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to load provider data and correct inappropriate claim denials timely

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$90,000

D3.VIII.7 Date assessed

02/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

02/21/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

25 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to meet case management requirements timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

n/a

D3.VIII.7 Date assessed

02/29/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

26 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit accurate reports

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$98,000

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

04/02/2024

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

27 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit accurate reports

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$2,000

D3.VIII.7 Date assessed

09/09/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

28 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Administration] Failure to provide complete HIPAA breach incident report timely

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

n/a

D3.VIII.7 Date assessed

05/08/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

29 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Administration] Failure to provide complete HIPAA breach incident report timely

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

n/a

D3.VIII.7 Date assessed

11/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

30 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to adhere to LDH directive to implement a rate change and reprocess claims

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

n/a

D3.VIII.7 Date assessed

07/18/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

31 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit complete and accurate reports timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$8,000

D3.VIII.7 Date assessed

07/29/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

32 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

[Enrollee Services] Failure to process member grievances and appeals timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

n/a

D3.VIII.7 Date assessed

09/19/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

33 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Provider Network] Failure to validate provider directory data and maintain an accuracy rate and improvement

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

02/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

34 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

02/21/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

35 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

03/04/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

36 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

05/22/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

37 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

08/08/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

38 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

11/26/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

39 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance
6

D3.VIII.6 Sanction amount
$100,000

D3.VIII.7 Date assessed
12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

40 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide nonemergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$5,000

D3.VIII.7 Date assessed
02/01/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance letter

41 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Inappropriate Denials of Third Party Liability Claims

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/22/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

42 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to meet case management requirements timely

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/29/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Compliance letter

43 / 110

Complete

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to meet case management requirements timely

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/24/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

44 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Administration] Failure provide complete HIPAA breach incident disclosure and report timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/20/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit complete and accurate reports

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/17/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 09/25/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit complete and accurate reports

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$240,000

D3.VIII.7 Date assessed

09/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to process member grievances timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Administration and Contract Management] Failure to ensure material subcontractor compliance

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

49 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to adhere to LDH Directive to Implement a rate change and reprocess claims

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/30/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

50 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

01/03/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

51 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

01/26/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

52 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

01/26/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

53 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

01/29/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

54 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

02/06/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

55 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

02/08/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Liquidated damages

56 / 110

Complete

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$120,000

D3.VIII.7 Date assessed

02/16/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

57 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$65,000

D3.VIII.7 Date assessed

02/21/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

58 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

03/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

59 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

03/22/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

60 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

05/01/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

61 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

07/02/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

62 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$2,500

D3.VIII.7 Date assessed

08/08/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

63 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$2,500

D3.VIII.7 Date assessed

09/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

64 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$2,500

D3.VIII.7 Date assessed

10/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Liquidated damages

65 / 110

Complete

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$7,500

D3.VIII.7 Date assessed

10/30/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

66 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

12/09/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

67 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide NEMT timely

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

02/01/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

68 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide NEMT timely

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

02/15/2024

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

69 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide NEMT timely

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

07/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

70 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide NEMT timely

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$10,000

4

D3.VIII.7 Date assessed

09/26/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

71 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Provider Network] Failure to validate provider directory data and maintain an accuracy rate and improvement.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

na

D3.VIII.7 Date assessed

02/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/07/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

72 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

01/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 07/12/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

73 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to adhere to LDH Directive and Reprocess Claims

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

03/05/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

74 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to adhere to LDH Directive and Reprocess Claims

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

07/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

75 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to meet encounter data submission requirement

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

05/22/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Compliance letter

76 / 110

Complete

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit complete and accurate reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

09/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

77 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to Notify Providers of System Error or “Glitch” and Reprocess Claims Timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

10/10/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Louisiana Healthcare Connections

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to meet case management requirements timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

10/25/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees timely.

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

03/22/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

80 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees timely.

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

07/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

81 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees timely.

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

07/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

82 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees timely.

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$7,500

D3.VIII.7 Date assessed

10/28/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

83 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance
16

D3.VIII.6 Sanction amount
$135,000

D3.VIII.7 Date assessed
01/26/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

84 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance
16

D3.VIII.6 Sanction amount
$40,000

D3.VIII.7 Date assessed
01/30/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

85 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

02/19/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

86 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$40,000

D3.VIII.7 Date assessed

03/20/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Liquidated damages

87 / 110

Complete

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

03/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

88 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

04/25/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

89 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

05/01/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

90 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

05/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

91 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$20,000

D3.VIII.7 Date assessed

07/17/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

92 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance
16

D3.VIII.6 Sanction amount
$45,000

D3.VIII.7 Date assessed
07/24/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

93 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance
16

D3.VIII.6 Sanction amount
$2,500

D3.VIII.7 Date assessed
08/19/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

94 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

09/20/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

95 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$12,500

D3.VIII.7 Date assessed

10/28/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Liquidated damages

96 / 110

Complete

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$2,500

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

97 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to provide non-emergency medical transportation to eligible enrollees.

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$2,500

D3.VIII.7 Date assessed

12/30/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

98 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Provider Network] Failure to validate provider directory data and maintain an accuracy rate and improvement

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

02/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

99 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Enrollee Services] Failure to provide MCO Member ID cards timely.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$2,000

D3.VIII.7 Date assessed

02/01/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

100 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

01/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 02/12/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

101 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to process retroactive disenrollment and recoupment timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

02/28/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

102 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit complete, accurate, and timely reports

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

05/16/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

103 / 110

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Reporting] Failure to submit complete, accurate, and timely reports

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
$38,000

D3.VIII.7 Date assessed
09/27/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance letter

104 / 110

D3.VIII.2 Plan performance issue
Performance improvement

D3.VIII.3 Plan name
UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Claims and Encounters] Failure to adhere to LDH directive to implement a rate change and reprocess claims

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
na

D3.VIII.7 Date assessed
07/18/2024

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance letter

105 / 110

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
UnitedHealthcare Community Plan

Performance improvement

D3.VIII.4 Reason for intervention

[Enrollee Services] Failure to process member grievances and appeals timely

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

09/19/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

106 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Enrollee Services] Failure to process member grievances and appeals timely

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

11/15/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Enrollee Services] Failure to process member grievances and appeals timely

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$95,000

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Enrollee Services] Failure to process member grievances and appeals timely

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

01/03/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

109 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Provider Reimbursement] Failure to make incentive payments to NEMT providers timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

10/17/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

110 / 110

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

UnitedHealthcare Community Plan

D3.VIII.4 Reason for intervention

[Services and Benefits] Failure to meet case management requirements timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

10/25/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Aetna Better Health of Louisiana** 4 **AmeriHealth Caritas Louisiana** 6 **Healthy Blue** 12 **Louisiana Healthcare Connections** 10 **UnitedHealthcare Community Plan** 7 **Humana Healthy Horizons** 6
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Aetna Better Health of Louisiana** 260 **AmeriHealth Caritas Louisiana** 380 **Healthy Blue** 328 **Louisiana Healthcare Connections** 566 **UnitedHealthcare Community Plan** 186 **Humana Healthy Horizons** 115
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health of Louisiana** 1.68:1,000 **AmeriHealth Caritas Louisiana** 2.14:1,000 **Healthy Blue** 1.15:1,000 **Louisiana Healthcare Connections**

		1.29:1,000 **UnitedHealthcare Community Plan** 0.48:1,000 **Humana Healthy Horizons** 0.85:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Aetna Better Health of Louisiana** 201 **AmeriHealth Caritas Louisiana** 229 **Healthy Blue** 335 **Louisiana Healthcare Connections** 540 **UnitedHealthcare Community Plan** 192 **Humana Healthy Horizons** 96
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health of Louisiana** 1.3:1,000 **AmeriHealth Caritas Louisiana** 1.29:1,000 **Healthy Blue** 1.17:1,000 **Louisiana Healthcare Connections** 1.23:1,000 **UnitedHealthcare Community Plan** 0.5:1,000 **Humana Healthy Horizons** 0.71:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program	**Aetna Better Health of Louisiana** Makes referrals to the SMA and MFCU concurrently

	integrity referrals to the state? Select one.	**AmeriHealth Caritas Louisiana** Makes referrals to the SMA and MFCU concurrently **Healthy Blue** Makes referrals to the SMA and MFCU concurrently **Louisiana Healthcare Connections** Makes referrals to the SMA and MFCU concurrently **UnitedHealthcare Community Plan** Makes referrals to the SMA and MFCU concurrently **Humana Healthy Horizons** Makes referrals to the SMA and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	**Aetna Better Health of Louisiana** 226 **AmeriHealth Caritas Louisiana** 29 **Healthy Blue** 370 **Louisiana Healthcare Connections** 250 **UnitedHealthcare Community Plan** 121 **Humana Healthy Horizons** 83
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals	**Aetna Better Health of Louisiana** 1.46:1,000 **AmeriHealth Caritas Louisiana** 0.16:1,000 **Healthy Blue**

	enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	1.29:1,000 **Louisiana Healthcare Connections** 0.57:1,000 **UnitedHealthcare Community Plan** 0.31:1,000 **Humana Healthy Horizons** 0.61:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Aetna Better Health of Louisiana** 04/01/2025 **AmeriHealth Caritas Louisiana** 04/01/2025 **Healthy Blue** 04/01/2025 **Louisiana Healthcare Connections** 04/01/2025 **UnitedHealthcare Community Plan** 04/01/2025 **Humana Healthy Horizons** 04/01/2025
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Aetna Better Health of Louisiana** 04/30/2025 **AmeriHealth Caritas Louisiana** 04/30/2025 **Healthy Blue** 04/30/2025 **Louisiana Healthcare Connections** 04/30/2025 **UnitedHealthcare Community Plan** 04/30/2025 **Humana Healthy Horizons** 04/30/2025
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount**	**Aetna Better Health of Louisiana** $2,252,099

	From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**AmeriHealth Caritas Louisiana** $1,980,887 **Healthy Blue** $5,345,736 **Louisiana Healthcare Connections** $1,140,276 **UnitedHealthcare Community Plan** $1,794,828 **Humana Healthy Horizons** $4,665,204
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Aetna Better Health of Louisiana** N/A **AmeriHealth Caritas Louisiana** N/A **Healthy Blue** N/A **Louisiana Healthcare Connections** N/A **UnitedHealthcare Community Plan** N/A **Humana Healthy Horizons** N/A
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Aetna Better Health of Louisiana** Promptly when plan receives information about the change **AmeriHealth Caritas Louisiana** Promptly when plan receives information about the change **Healthy Blue** Promptly when plan receives information about the change **Louisiana Healthcare Connections**

Promptly when plan receives information about the change

UnitedHealthcare Community Plan

Promptly when plan receives information about the change

Humana Healthy Horizons

Promptly when plan receives information about the change

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Aetna Better Health of Louisiana** Not answered **AmeriHealth Caritas Louisiana** Not answered **Healthy Blue** Not answered **Louisiana Healthcare Connections** Not answered **UnitedHealthcare Community Plan** Not answered **Humana Healthy Horizons** Not answered

Topic XIII. Prior Authorization

> ⚠ **Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services** Enrollment Broker/Choice Counseling Beneficiary Outreach