State Fiscal Year July 1, 2023–June 30, 2024

External Quality Review Technical Report

for
Aetna Better Health

February 2025

Table of Contents

Acknowledgments and Copyrights

1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral health care and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a 1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 16, 2024.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 16, 2024.

health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2024 (July 1, 2023–June 30, 2024) are displayed in Table 1-1. Of note, no MCEs are exempt from EQR.

Table 1-1—Louisiana's Medicaid MCEs

MCE Name	Plan Type	Services Provided	Service Region	Acronym or Abbreviated Reference
Aetna Better Health	MCO	Behavioral and physical health	Statewide	ABH
AmeriHealth Caritas Louisiana	MCO	Behavioral and physical health	Statewide	ACLA
Healthy Blue	MCO	Behavioral and physical health	Statewide	HBL
Humana Healthy Horizons	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA
Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS EQR Protocols released in February 2023.[1-3] For the SFY 2024 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about the quality, timeliness, and accessibility of healthcare services provided by each MCE. Table 1-2 depicts the EQR activities conducted for each plan type.

Table 1-2—EQR Activities Conducted for Each Plan Type

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
Performance Improvement Project (PIP) Validation	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting, and whether the PIP demonstrated significant improvement in performance.	Protocol 1. Validation of Performance Improvement Projects	✓	✓	✓
Performance Evaluation and Improvement	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures	✓	✓	✓
Compliance Reviews (CRs)	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations	✓	✓	✓
Network Adequacy and Availability Validation (NAV)	The audit activity assesses the accuracy of the state-defined network adequacy indicators reported by the MCEs; evaluates the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used; and determines the overall phases of design, data collection, analysis, and interpretation of the network	Protocol 4. Validation of Network Adequacy	✓	✓	✓

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
	adequacy indicators, as set forth by the State. Additionally, this activity evaluates the accuracy of provider directory information submitted by the MCOs and determines appointment availability information by conducting telephone surveys among a sample of providers.				
Consumer Surveys: CAHPS-A and CAHPS-C	This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Behavioral Health Member Satisfaction Survey	This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Health Disparities Focus Study	This activity uses data collected from the five MCOs to identify health disparities based on race, ethnicity, and geography, where applicable, at the statewide and MCO levels.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management services to determine the number of individuals, the types of conditions, and the impact that case management services have on members receiving those services.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
Quality Rating System (QRS)	This activity evaluates and applies a rating to measure the quality of care and performance of the MCOs to provide information to help eligible members choose an MCO.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs	✓		

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2024. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

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

Definitions

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

Quality	Timeliness	Access
as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]	as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[1]

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

Methodologies

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

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO, as well as the program overall. To produce Healthy Louisiana's MCO aggregate SFY 2024 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs:

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

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

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

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

Louisiana's Medicaid Managed Care Quality Strategy

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

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

Goals and Objectives

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

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

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

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

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

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

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

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

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

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

Overall, the quality strategy serves to effectively measure and improve the quality of Louisiana's Medicaid managed care services. LDH's initiatives tie to the quality strategy aims, goals, and objectives. The quality strategy also promotes identification and implementation of initiatives to monitor, assess, and improve access to care, quality of care, and timeliness of service delivery for Louisiana Medicaid

[1-4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Dec 16, 2024.

members. LDH plans to incorporate goals from the National Quality Strategy in the quality strategy in the future. LDH oversees the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. LDH has an MCO contract requirement that the MCO should be committed to QI. Each MCO is required to be NCQA accredited and to conduct HEDIS performance measure reporting. LDH plans to also include the requirement for a commitment to QI in the PAHP contract.

Recommendations

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH identify a measure to align with the following objectives:
  - Ensure appropriate hospice onboarding and transitioning from palliative care to hospice.
  - Promote early initiation of palliative care to improve quality of life.
  - Promote health development and wellness in children and adolescents.
  - Advance specific interventions to address social determinants of health.
  - Advance value-based payment arrangements and innovation.
  - Ensure members who are improving or stabilized in hospice are considered for discharge.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends LDH include performance measures for the PAHPs and PIHP in the quality strategy.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH continue to work with the MCEs during PIP and Medicaid Advisory Committee (MAC) meetings to discuss best practices for performance measures. During these discussions, LDH could focus on specific performance measures in the quality strategy that have not met improvement objectives and target objectives.
- To improve MCO performance in Goal 6, "Partner with communities to improve population health and address health disparities," HSAG recommends that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans and the progress being made through quality interventions to reduce health disparities.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends LDH assess MCO failure to provide non-emergency medical transportation (NEMT) and have the MCOs implement interventions to improve provision of NEMT and ensure it is timely and accessible.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH assess areas of noncompliance that resulted in an MCO receiving a notice of

monetary penalty. This assessment should identify root causes for noncompliance and then work to identify appropriate interventions to eliminate noncompliance and improve performance.

- HSAG recommends that LDH report rates for the following measures:
  - Enrollment by Product Line
  - Language Diversity of Membership
  - Race/Ethnicity Diversity of Membership

Actions on External Quality Review Recommendations

The EQRO identified the following recommendations for the quality strategy during SFY 2022–2023. These recommendations included how LDH could target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 includes the recommendations that the EQRO made to LDH to support program improvement and progress in meeting the goals of the quality strategy. The State's responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Table 1-3—SFY 2022–2023 EQRO Recommendations and LDH Actions

SFY 2022–2023 EQRO Recommendations	LDH Actions
HSAG recommended LDH consider a change in metric benchmarks so the MCEs can strive toward a consistent performance level. HSAG recommended LDH remove the target objectives and improvement objectives and establish benchmarks for all MCEs that align with nationally recognized quality measures (e.g., NCQA Quality Compass,[1-5] CMS Adult and Child Core Sets) or the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.	LDH declined to change the target objectives and improvement objectives.
HSAG recommended LDH consider using the measurement year (MY) 2023 reported rates in the 2024 quality strategy evaluation, which could include MY 2021 through MY 2023 results in order to include the most current data for evaluation.	LDH agreed to use the MY 2023 reported rates in the 2024 quality strategy evaluation.
HSAG recommended LDH remove the duplicate objective, promote healthy development and wellness in children and adolescents.	LDH updated the quality strategy to remove this duplicate objective.
HSAG recommended LDH consider adding the objectives, improve overall health and promote reproductive health objectives, to the quality strategy.	LDH updated the quality strategy to include these two objectives.
HSAG recommended LDH continue to collaborate with the MCOs to support adequate QI capacity, skills, and resources to support current and future PIPs. HSAG recommended LDH continue to meet	LDH will continue to meet and collaborate with the MCOs related to PIPs. LDH agreed with the EQRO's

[1-5] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

SFY 2022–2023 EQRO Recommendations	LDH Actions
regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could consider incorporating a similar mechanism for the PAHPs to collaborate on current and future PIPs. HSAG also recommended LDH consider hosting a forum in which the MCEs could discuss programwide solutions to overcome barriers. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.	recommendation to incorporate a similar PIP collaboration process for the PAHPs, and the process is currently being developed. Lastly, LDH considers the monthly PIP meetings to be an avenue for discussing programwide solutions to overcome barriers.
HSAG recommended LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.	LDH declined to change the improvement targets' time period.
HSAG recommended the MCEs consider whether there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommended the MCEs target QI interventions to reduce the identified disparities.	The MCOs document this process in their annual health equity plans.
HSAG recommended LDH consider working with the MCEs to share performance measure best practices and identify interdependencies across measures.	LDH currently works with the MCEs collaboratively during monthly and quarterly PIP meetings as well as quarterly MAC meetings. The MAC consists of MCE chief medical officers (CMOs). Best practices are discussed frequently. In addition, LDH meets with the MCO chief executive officers (CEOs) and other support staff during quarterly business reviews to discuss recommendations and best practices.
HSAG recommended LDH consider a contract statement for all MCEs that the MCEs' quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.	LDH plans to add a similar statement to the dental contract. Quality is being revamped and expanded for dental. LA Medicaid will also work with OBH to incorporate in the CSoC contracts.
HSAG recommended LDH consider removing Aim statements from the quality strategy. CMS defines "quality strategy goals" as SMART (specific, measurable, attainable, relevant, and time-bound), high-level managed care performance aims that provide direction for the State. CMS defines "quality strategy (SMART) objectives" as measurable steps toward meeting the State's goals that typically include quality measures.	LDH plans to move to incorporate the CMS National Quality Strategy to encompass the four National Quality Strategy priority areas.

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for Aetna Better Health (ABH) conducted with Louisiana Medicaid managed care throughout SFY 2024.

Validation of Performance Improvement Projects

With the start of HSAG's EQRO contract with LDH in March 2023, HSAG initiated PIP validation training and technical assistance activities to assist LDH, ABH, and other MCOs in transitioning to HSAG's PIP validation process and methodology. ABH actively worked on PIPs throughout SFY 2024, and PIP validation activities were initiated. LDH required ABH to conduct PIPs on the following state-mandated topics during SFY 2024:

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

At the time this report was drafted, HSAG's first validation cycle of ABH's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP was in progress and is scheduled to be completed in SFY 2025; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations for this PIP will be reported in next year's annual EQR technical report.

Validation of Performance Measures

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

Information Systems Capabilities Assessment

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

HEDIS—Quality, Timeliness, and Access

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2023 NCQA national 50th percentile, which served as the benchmark. A total of 47 measures, comprising 290 measure indicators, were selected for analysis. Of the 290 measure indicators, 12 were not reported in Quality Compass and were therefore excluded from comparisons to NCQA national 50th percentile benchmarks.

Of the 278 HEDIS measures/measure indicators with an associated benchmark, ABH had 163 indicators that performed greater than the NCQA national 50th percentile benchmark, 113 that performed lower than the NCQA national 50th percentile benchmark, and two indicators that were not compared to the NCQA national 50th percentile benchmark because the reported rates were *Not Applicable (NA)* (i.e., small denominator). Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG reviewed the corrective action plans (CAPs) that ABH prepared to remediate any deficiencies identified during the 2023 CR. HSAG and LDH evaluated the sufficiency of the CAPs. ABH achieved compliance in six of six elements from the 2023 CAPs. ABH demonstrated that it successfully remediated all six elements, indicating the necessary initiatives were implemented and demonstrated compliance with the requirements under review.

HSAG will conduct a comprehensive CR during 2025 to determine the extent to which the MCOs are in compliance with federal standards during the review period CY 2024.

Validation of Network Adequacy

Provider Directory Validation

HSAG's provider directory validation (PDV) indicated that, overall, the provider information maintained and provided by ABH was poor, which impacted access to care due to the inability of members to find a provider that delivered the requested services. Table 1-4 provides a summary of the findings from the study.

Table 1-4—Summary of PDV Findings

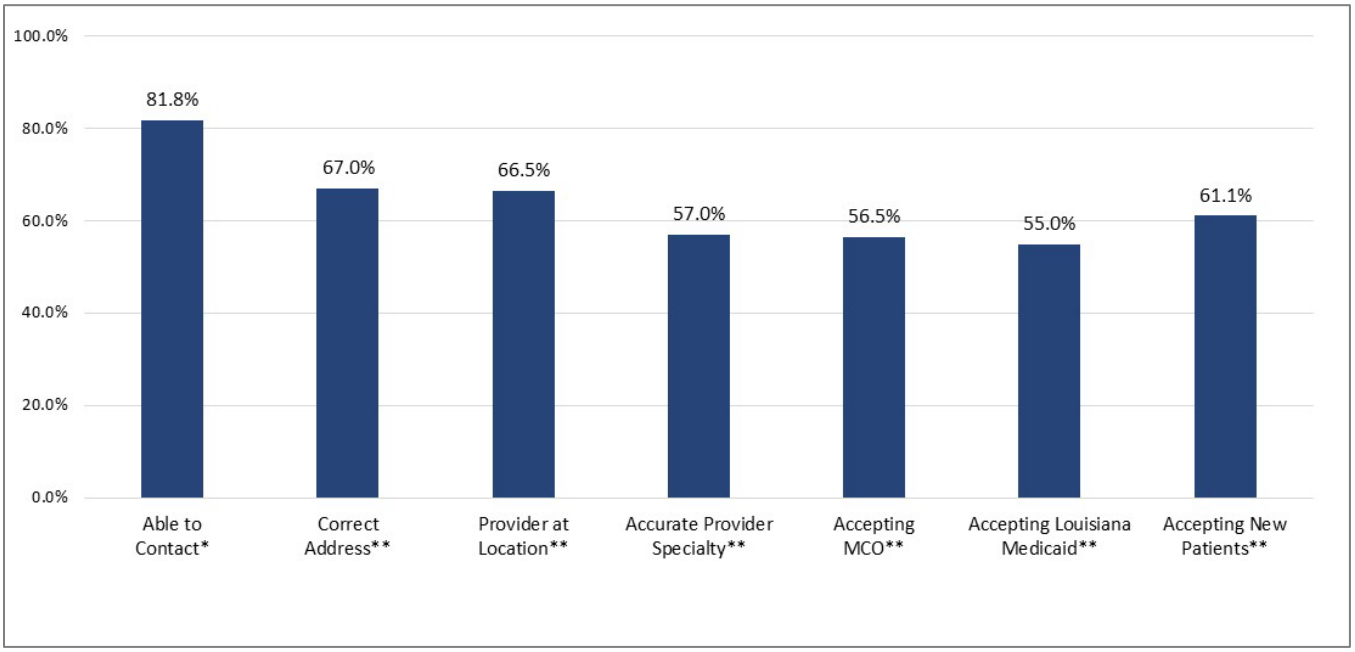
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 55.0 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 56.5 percent of providers accepted the requested MCO.
Provider's specialty in the provider directory was incorrect.	Overall, 57.0 percent of providers confirmed the specialty listed in the online provider directory was accurate.

Concerns	Findings
Overall acceptance of new patients was low.	Overall, 61.1 percent of providers accepted new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews.
Affiliation with the sampled provider was low.	Overall, 66.5 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 67.0 percent of respondents reported that ABH's provider directory reflected the correct address.

While the overall PDV response rate was relatively high at 81.8 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of the provider's specialty, Louisiana Medicaid acceptance, and ABH acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate below 70.0 percent.

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

Figure 1-1—Summary Results for All Sampled ABH Providers



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

ABH's weighted PDV compliance scores by specialty type ranged from 24.3 percent (specialists) to 54.3 percent (pediatrics).

Provider Access Survey

HSAG's provider access survey indicated that, overall, the provider information maintained and provided by ABH was poor. Table 1-5 provides a summary of the findings from the study.

Table 1-5—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 21.9 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 34.9 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of Louisiana Medicaid was low.	Overall, 38.4 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 43.2 percent of providers accepted the requested MCO.
Provider's specialty in the provider data was inaccurate.	Overall, 49.3 percent of providers confirmed the specialty listed in the provider data was accurate.
Address information was inaccurate.	Overall, 89.0 percent of locations confirmed the address listed in the provider data was accurate.

Table 1-6 presents the provider access survey call outcomes.

Table 1-6—Provider Access Survey Call Outcomes

Specialty	Able to Contact[1]	Correct Address[2]	Offering Services[2]	Accepting MCO[2]	Accepting Medicaid[2]	Accepting New Patients[2]	Confirmed Provider[2]
Total	**77.7%**	**89.0%**	**49.3%**	**43.2%**	**38.4%**	**34.9%**	**21.9%**
Primary Care	73.3%	93.2%	63.6%	52.3%	45.5%	40.9%	18.2%
Pediatrics	75.0%	86.7%	26.7%	23.3%	20.0%	16.7%	10.0%
Obstetricians/ Gynecologists (OB/GYNs)	85.0%	94.1%	70.6%	70.6%	70.6%	70.6%	47.1%
Endocrinologists	83.3%	90.0%	60.0%	40.0%	40.0%	30.0%	20.0%
Dermatologists	77.8%	92.9%	71.4%	71.4%	57.1%	50.0%	42.9%
Neurologists	85.0%	88.2%	11.8%	11.8%	11.8%	11.8%	11.8%
Orthopedic Surgeons	77.8%	71.4%	42.9%	35.7%	28.6%	28.6%	21.4%

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.

ABH's weighted provider access survey compliance scores by specialty type ranged from 29.4 percent (primary care) to 56.7 percent (neurologists). ABH's after-hours weighted provider access survey compliance scores by specialty type ranged from 0.0 percent (dermatologists, neurologists, and orthopedic surgeons) to 46.7 percent (OB/GYNs).

NAV Audit

HSAG identified no network adequacy indicators in scope of review received a *No Confidence* or *Low Confidence* validation rating determination.

Table 1-7 contains the provider types, at the statewide level, by urbanicity, for which ABH achieved the 100 percent threshold for 100 percent of members to have access.

Table 1-7—ABH Distance Requirements Met by 100 Percent of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity
Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine and Physician Extenders)	Rural
Pediatrics (Family/General Practice; Internal Medicine and Physician Extenders)	Rural
Rural Health Clinics (RHCs)	Rural
Pharmacy	Rural
Behavioral Health Specialist (Other Specialty Care: Advanced Practice Registered Nurse [APRN-BH] specialty, Licensed Psychologist or Licensed Clinical Social Worker [LCSW])	Rural
Psychiatric Residential Treatment Facilities (PRTFs), PRTF (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	Urban
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban
	Rural

HSAG assessed ABH's results for statewide provider-to-member ratios by provider type and determined that ABH's statewide results met or exceeded LDH-established requirements.

HSAG assessed ABH's results for behavioral health providers to determine the accessibility and availability of appointments and determined that ABH met all LDH-established performance goals for three reported appointment access standards, as displayed in Table 1-8.

Table 1-8—ABH Appointment Access Standards Compliance Rate for Behavioral Health

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	100%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	99.0%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	100%

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared ABH's 2024 achievement scores to its corresponding 2023 achievement scores and the 2024 NCQA national averages to determine whether there were statistically significant differences. Overall, ABH's 2024 general child achievement score was statistically significantly higher than the 2024 NCQA national average for *Getting Care Quickly*. Furthermore, ABH's 2024 adult achievement score was statistically significantly lower than the 2024 NCQA national average for *Rating of All Health Care*.

Behavioral Health Member Satisfaction Survey

HSAG compared ABH's 2024 achievement scores to the 2024 Healthy Louisiana statewide average (SWA) and 2023 scores to determine whether there were statistically significant differences. Overall, ABH's 2024 child achievement score was statistically significantly lower than the 2023 score for *Treatment or Counseling Convenience*. Several measures had less than 100 respondents. ABH should focus on increasing response rates to the behavioral health member satisfaction survey for its adult and child populations.

Health Disparities Focus Study

While the 2023 Annual Health Disparities Focus Study included MCO-specific findings, the overall results and conclusions of this study are not MCO-specific. Therefore, please refer to the annual MCO aggregate technical report for high-level statewide findings from the 2023 Annual Health Disparities Focus Study.

Case Management Performance Evaluation

During SFY 2024, HSAG conducted two CMPE reviews. HSAG evaluated the MCOs' compliance with the case management provisions of their contracts with LDH, including the rates of engagement in case management; the specific services offered to enrollees receiving case management; and the

effectiveness of case management in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

The reviews identified successes and opportunities for improvement, which were used by LDH to inform guidance and develop CAPs to address performance. The following strengths were identified for ABH:

- The results of both reviews demonstrated that no findings resulted in concerns regarding an enrollee's health, safety, or welfare.
- The results of both reviews demonstrated that the health plan was successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans, and multidisciplinary care team (MCT) development.

ABH demonstrated opportunity for improvement with elements related to ongoing scheduled case management activities. Specific findings and recommended actions were provided to ABH through HSAG's CAP process. ABH successfully completed remediation actions to address the CAP findings, and the CAP was closed in October 2024.

Quality Rating System

Figure 1-2 displays the 2024 Health Plan Report Card, which presents the 2024 rating results for each MCO. The 2024 Health Plan Report Card shows that, for the Overall Rating, ABH received 3.5 stars. ABH received 5.0 stars, 4.5, and 4.0 stars for the Equity, Getting Care, and Behavioral Health—Access, Monitoring, and Safety subcomposites, respectively, demonstrating strength for ABH in these areas. However, ABH received 2.5 stars for the Prevention and Equity composite, including 2.0 stars for the Children/Adolescent Well-Care and Cancer Screening subcomposites. Further, ABH also received 2.0 stars and 1.5 stars for the Reduce Low Value Care and Behavioral Health—Care Coordination subcomposites, respectively, demonstrating opportunities for improvement for ABH in these areas.

Figure 1-2—2024 Health Plan Report Card

Issued 08/2024

Healthy Louisiana

2024 HEALTH PLAN REPORT CARD

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

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

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

Continued on next page...

Figure 1-2—2024 Health Plan Report Card (cont.)

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

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

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

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

NC indicates that the plan received a rating of 0 for the measure in this composite.

This report card is reflective of data collected between January 2023 and December 2023.

The categories and measures included in this report card are based on the 2024 National Committee for Quality Assurance (NCQA) Health Plan Ratings and LDH required measures lists. When feasible, categories and measures were kept consistent with the prior year's health plan report card, but some measures and categories were removed due to data availability. Any analysis, interpretation, and conclusions based on the data is solely that of the author. Anyone desiring to use or reproduce the materials must obtain approval from LDH.

2. Validation of Performance Improvement Projects

Results

SFY 2024 (review period) was the second year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs, including ABH, to carry out PIPs to address five state-mandated topics that were validated during SFY 2024. LDH also required the MCOs to initiate a new PIP topic, *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*, in January 2024 to be validated during SFY 2025. Table 2-1 summarizes the PIP topics carried out by ABH in SFY 2024.

Table 2-1—SFY 2024 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Behavioral Health Transitions of Care	• 6 years and older • 13 years and older
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• 5–11 years • 12–15 years • 16 years and older
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• 6 months–18 months • 19 months–2 years • 3–5 years
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• 21–64 years
Screening for HIV Infection	• 13 years and older • 15–65 years
*Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees**	• *Not applicable*

*PIP to be validated during SFY 2025.

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

Table 2-2 summarizes key PIP validation milestones that occurred from July 2023 through June 2024, the end of SFY 2024.

Table 2-2—SFY 2024 MCO PIP Activities

PIP Activities and Milestones	Dates
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	July 2023–June 2024
The MCOs submitted Quarter 2 2023 PIP updates	July 2023
HSAG provided initial PIP proposal validation findings to the MCOs	September 2023
The MCOs submitted Quarter 3 2023 PIP updates	October 2023
The MCOs submitted draft PIP reports, to HSAG for validation	January 2024
The MCOs submitted Quarter 1 2024 PIP updates	April 2024
HSAG provided draft PIP report validation findings to the MCOs	February 2024
The MCOs submitted final PIP reports to HSAG for validation	March 2024
HSAG provided final PIP validation reports to the MCOs	April 2024

In SFY 2025, ABH will submit draft PIP reports for initial validation in January 2025 and the final PIP reports for final validation in March 2025. HSAG will complete the second annual validation cycle in April 2025.

Validation Results and Confidence Ratings

Table 2-3 summarizes ABH's final PIP validation results and confidence ratings delivered by HSAG in April 2024.

Table 2-3—SFY 2024 PIP Validation Results for ABH

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Transitions of Care	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	85%	89%	*Low Confidence*	33%	100%	*Moderate Confidence*

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

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

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

Performance Indicator Results

Table 2-4 displays data for ABH's *Behavioral Health Transitions of Care* PIP.

Table 2-4—Performance Indicator Results for the *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 469 D: 2,845	16.49%	N: 567 D: 3,162	17.93%			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 968 D: 2,845	34.02%	N: 1,132 D: 3,162	35.80%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 85 D: 451	18.85%	N: 117 D: 585	20.00%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 141 D: 451	31.26%	N: 190 D: 585	32.48%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 115 D: 903	12.74%	N: 291 D: 1,312	22.18%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 166 D: 903	18.38%	N: 431 D: 1,312	32.85%▲			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-5 displays data for ABH's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-5—Performance Indicator Results for the *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 61,361 D: 119,997	51.14%	N: 59,054 D: 115,387	51.18%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 53,937 D: 119,997	44.95%	N: 51,794 D: 115,387	44.89%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 19,056 D: 43,319	43.99%	N: 17,074 D: 39,406	43.33%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 25,516 D: 45,109	56.57%	N: 26,603 D: 46,500	57.21%▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 4,292 D: 9,858	43.54%	N: 6,093 D: 13,510	45.10%▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 12,497 D: 21,711	57.56%	N: 9,284 D: 15,971	58.13%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 16,691 D: 43,319	38.53%	N: 14,964 D: 39,406	37.97%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 22,353 D: 45,109	49.55%	N: 23,249 D: 46,500	50.00%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 3,580 D: 9,858	36.32%	N: 5,166 D: 13,510	38.24%▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 11,313 D: 21,711	52.11%	N: 8,415 D: 15,971	52.69%	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 2,381 D: 38,752	6.14%	N: 2,960 D: 10,318	28.69% ▲	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 1,975 D: 38,752	5.10%	N: 2,341 D: 10,318	22.69% ▲	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 2,246 D: 38,752	5.80%	N: 2,688 D: 19,834	13.55% ▲	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 1,679 D: 38,752	4.33%	N: 1,995 D: 19,834	10.06% ▲	*Not Assessed*

N–Numerator D–Denominator
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

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

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

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 152 D: 3,300	4.60%	N: 135 D: 3,478	3.88%			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 291 D: 4,060	7.16%	N: 281 D: 4,450	6.31%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 280 D: 6,680	4.19%	N: 262 D: 7,080	3.70%			*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 723 D: 14,040	5.15%	N: 678 D: 15,008	4.52%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

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

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

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 14,749 D: 30,785	47.91%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-8 displays data for ABH's *Screening for HIV Infection* PIP.

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

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 2,154 D: 3,776	57.04%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 3,225 D: 9,390	34.35%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,238 D: 10,890	48.10%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 25,261 D: 79,552	31.75%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Interventions

Table 2-9 summarizes ABH's final CY 2023 barriers and interventions.

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

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge • Providers do not receive details of enrollee's diagnosis and discharge plan • Enrollees not aware of the importance of follow-up care	• Enhanced admission, discharge, and transfer (ADT) data exchange for BH related emergency department (ED) visits and hospital stays. • Information technology system enhancements to connect follow-up providers with *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* discharge plans. • Enrollee follow-up educational campaign to provide information on the importance of follow-up visits

PIP Topic	Barriers	Interventions
		and assist with follow-up appointment scheduling.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Enrollees may not remember to obtain the second dose of a two dose vaccine series	• Distributed eligible enrollee lists and vaccination site lists to PCPs and facilitate referrals as needed.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application • Lack of enrollee parent/guardian understanding of benefits and importance of fluoride varnish treatment	• Enhanced MCO case management enrollee outreach and education with dental provider appointment scheduling. • Utilization of technology to ensure education on receiving fluoride varnish treatment in PCP offices for guardians of eligible enrollees. • Educate PCPs on the practice of applying fluoride varnish in the office setting and appropriate documentation of Current Procedural Terminology (CPT) code 99188. • Worked with providers to ensure that fluoride varnish treatments are occurring in the office.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Enrollees may not remember to schedule annual preventive appointments, which include cervical cancer screening	• Enrollee education regarding Centers for Disease Control and Prevention (CDC) cervical cancer screening guidelines related to recommended ages, types of screening methods, and populations who should receive screening. • Telephonic and text outreach campaigns to eligible enrollees to provide appointment scheduling and transportation assistance for cervical cancer screening. • Partnered with Crescent Care clinic to provide a community event that included enrollee education and the opportunity for enrollees to be screened during the event.

PIP Topic	Barriers	Interventions
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Text message campaign and printed enrollee educational materials on HIV statistics and HIV screening guidelines. • Community events to provide enrollees with HIV education and screening opportunities.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- The MCO developed and carried out a methodologically sound design for all five PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The MCO conducted and reported accurate analyses and interpretation of performance indicator results for four of the five PIPs. **[Quality]**
- The MCO carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCO collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all five PIPs. **[Quality]**
- For two (*Behavioral Health Transitions of Care* and *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees*) of the three PIPs assessed for achieving significant improvement, the MCO's reported performance indicator results demonstrated some improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For ABH, the following opportunities for improvement were identified:

- For one PIP, *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees,* the MCO inaccurately reported some performance indicator data and statistical testing results in the final PIP submission. **[Quality]**
- For one PIP, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*, the MCO's reported performance indicator results did not demonstrate any improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For ABH, the following recommendations were identified:

- The MCO should ensure that the internal data analysis and documentation processes used for evaluating and reporting PIP indicator results include a quality check so that all indicator results and statistical testing results are accurately reported for each PIP. **[Quality]**

- To facilitate significant outcomes improvement for all PIPs, the MCO should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCO should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

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

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

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

Technical Methods of Data Collection

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

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

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

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

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

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across the MCOs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

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

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of an MCO's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-10.

Table 2-10—Assignment of PIPs to the Quality, Timeliness, and Access Domains

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

3. Validation of Performance Measures

Results

Information Systems Standards Review

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

Based on a review of the FARs issued by ABH's independent certified HEDIS compliance auditor, HSAG found that ABH fully met the standard for all four of the applicable NCQA IS standards. ABH's compliance with each of the IS standards is outlined in Table 3-1.

Table 3-1—ABH Compliance With IS Standards—MY 2022 and MY 2023 Comparison

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

Performance Measures

In SFY 2024 (review period), LDH required each contracted MCO to collect and report on 47 HEDIS measures, which includes 290 total measure indicators for HEDIS MY 2023 specified in the provider agreement. The measurement set includes 11 incentive measures. Table 3-2 displays the 290 measure indicators required by LDH. **Red** cells indicate that the measure fell below the NCQA national 50th percentile, **green** cells indicate that the measure was at or above the NCQA national 50th percentile. Table 3-2 through Table 3-5 display a summary of ABH's HEDIS measure performance.

Table 3-2—ABH HEDIS Effectiveness of Care Performance Measures—MY 2022 and MY 2023 Comparison

HEDIS Measure	MY 2022	MY 2023	SWA
Follow-Up After Hospitalization for Mental Illness			
Within 7 Days of Discharge	17.29%	18.61%	**20.67%**
Within 30 Days of Discharge[1]	35.27%	37.03%	**39.62%**
Follow-Up After Emergency Department Visit for Mental Illness			
Within 7 Days of Discharge	20.18%	20.76%	**22.26%**
Within 30 Days of Discharge[1]	33.57%	33.39%	**36.83%**

HEDIS Measure	MY 2022	MY 2023	SWA
Follow-Up After Emergency Department Visit for Substance Use[B]			
Within 7 Days of Discharge	22.24%	15.38%	**13.46%**
Within 30 Days of Discharge[I]	33.81%	24.59%	**21.75%**
Plan All-Cause Readmissions*			
Observed Readmissions (Numerator/Denominator)	10.37%	11.18%	**10.13%**
Expected Readmissions Rate	9.79%	10.38%	**9.77%**
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.0594	1.0778	**1.0368**
Depression Screening and Follow-Up for Adolescents and Adults			
Depression Screening (Total)	0.00%	0.78%	**1.06%**
Follow-Up on Positive Screen (Total)	0.00%	83.33%	**62.50%**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.33%	85.69%	**84.36%**
Diabetes Monitoring for People With Diabetes and Schizophrenia	63.26%	70.70%	**72.29%**
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.65%	83.33%	**81.53%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing	56.23%	60.00%	**54.92%**
Cholesterol Testing	30.70%	30.00%	**28.09%**
Blood Glucose and Cholesterol Testing	30.70%	29.38%	**27.21%**
Lead Screening in Children	62.04%	67.64%	**66.40%**
Childhood Immunization Status			
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	61.56%	70.32%	**71.31%**
Polio Vaccine, Inactivated (IPV)	81.51%	88.32%	**87.17%**
Measles, Mumps, and Rubella (MMR)	80.29%	84.43%	**86.06%**
Haemophilus Influenzae Type B (HiB)	79.32%	86.86%	**85.66%**
Hepatitis B	83.45%	90.02%	**89.20%**
Varicella-Zoster Virus (VZV)	80.29%	84.67%	**86.30%**
Pneumococcal Conjugate	64.48%	67.40%	**70.65%**
Hepatitis A	77.62%	80.78%	**83.82%**
Rotavirus	65.69%	63.99%	**63.96%**
Influenza	25.06%	25.30%	**21.26%**
Combination 3[I]	57.66%	63.02%	**64.96%**
Combination 7	50.36%	50.85%	**53.34%**
Combination 10	17.27%	17.03%	**16.16%**

HEDIS Measure	MY 2022	MY 2023	SWA
Immunizations for Adolescents			
Meningococcal	76.89%	79.32%	**85.85%**
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	76.40%	79.08%	**86.29%**
Human Papillomavirus (HPV)	30.17%	37.96%	**41.77%**
Combination 1	75.91%	78.59%	**85.64%**
Combination 2[I]	29.68%	37.47%	**41.53%**
Colorectal Cancer Screening[I]	31.85%	43.21%	**43.44%**
Flu Vaccinations for Adults Ages 18 to 64	33.33%	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
Body Mass Index (BMI) Percentile Documentation	77.62%	80.05%	**80.09%**
Counseling for Nutrition	66.67%	65.69%	**64.97%**
Counseling for Physical Activity	62.29%	63.50%	**57.89%**
HIV Viral Load Suppression[B, I]	80.62%	85.16%	**82.26%**
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.67%	27.93%	**26.35%**
Chlamydia Screening in Women			
Total	59.22%	64.55%	**65.84%**
Breast Cancer Screening	54.72%	—	—
Controlling High Blood Pressure[I]	59.85%	63.26%	**60.47%**
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	81.37%	82.75%	**82.74%**
Statin Adherence 80%—Total	73.65%	75.15%	**66.40%**
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes			
Poor HbA1c Control (>9.0%)[*,I]	33.09%	33.33%	**29.55%**
HbA1c Control (<8.0%)	56.20%	59.61%	**63.65%**
Eye Exam for Patients With Diabetes	52.31%	46.96%	**55.06%**
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)	61.31%	62.29%	**65.25%**
Pharmacotherapy for Opioid Use Disorder	34.26%	38.41%	**29.53%**
Initiation and Engagement of Substance Use Disorder (SUD) Treatment			
Initiation of SUD Treatment	60.02%	61.26%	**57.95%**
Engagement of SUD Treatment	25.54%	26.94%	**24.37%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67.24%	68.80%	**63.06%**

HEDIS Measure	MY 2022	MY 2023	SWA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.81%	58.31%	**55.72%**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication			
Initiation Phase	43.29%	43.17%	**45.52%**
Continuation and Maintenance Phase	60.00%	63.39%	**54.23%**
Antidepressant Medication Management			
Effective Acute Phase Treatment	60.92%	61.92%	**57.61%**
Effective Continuation Phase Treatment	45.35%	46.12%	**39.77%**
Appropriate Treatment for Children With Upper Respiratory Infection	79.17%	79.68%	**80.50%**
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	51.77%	50.75%	**51.81%**
Use of Imaging Studies for Low Back Pain[B]	69.73%	67.96%	**69.31%**
Non-Recommended Cervical Screening in Adolescent Females[*]	0.58%	0.50%	**1.85%**
Cervical Cancer Screening[I]	52.07%	48.66%	**53.47%**
Asthma Medication Ratio			
5–11 Years	—	84.14%	**76.33%**
12–18 Years	—	85.71%	**69.59%**
19–50 Years	—	74.73%	**68.05%**
51–64 Years	—	81.82%	**67.00%**
Total	—	79.36%	**70.18%**
Topical Fluoride for Children			
1–2 Years	—	1.42%	**4.76%**
3–4 Years	—	0.64%	**6.32%**
Total	—	1.00%	**5.56%**
Oral Evaluation, Dental Services			
0–2 Years	—	NA	**NA**
3–5 Years	—	NA	**NA**
6–14 Years	—	NA	**NA**
15–20 Years	—	NA	**NA**
Total	—	NA	**NA**

[*] Indicates a lower rate is desirable.
[B] Indicates a break in trending between the most recent year and the prior year.
[I] Incentive Measure.
Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.
For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.
— is presented for measures that were not reported by the MCOs in MY 2022 and indicates that MY 2022 rates are not available for those measures.

Table 3-3—ABH HEDIS Access to/Availability of Care Performance Measures—MY 2022 and MY 2023 Comparison

HEDIS Measure	MY 2022	MY 2023	SWA
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	62.73%	67.99%	**71.25%**
45–64 Years	75.53%	80.95%	**80.87%**
65 Years and Older	71.82%	68.44%	**79.46%**
Total	67.43%	72.59%	**74.25%**
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	76.40%	81.02%	**82.12%**
Postpartum Care	80.05%	77.37%	**77.27%**

Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.

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

HEDIS Measure	MY 2022	MY 2023	SWA
Well-Child Visits in the First 30 Months of Life			
First 15 Months	58.55%	68.42%	**64.44%**
15 Months–30 Months	61.09%	70.22%	**70.10%**
Child and Adolescent Well-Care Visits			
3–11 Years	50.72%	54.70%	**57.47%**
12–17 Years	43.09%	50.85%	**54.10%**
18–21 Years	22.79%	27.60%	**29.30%**
Total	43.80%	48.72%	**51.39%**
Ambulatory Care			
Outpatient Visits/1,000 Member Years	4,303.35	4,490.94	**4,958.45**
*Emergency Department Visits/1,000 Member Years**	745.11	774.29	**735.72**
Inpatient Utilization—General Hospital/Acute Care			
Maternity—Days/1,000 Member Years—10–19 Years	—	18.18	**28.03**
Maternity—Days/1,000 Member Years—20–44 Years	—	119.74	**149.64**
Maternity—Days/1,000 Member Years—45–64 Years	—	3.04	**1.85**
Maternity—Days/1,000 Member Years—Total	—	65.55	**82.50**
Maternity—Discharges/1,000 Member Years—10–19 Years	—	6.53	**9.72**
Maternity—Discharges/1,000 Member Years—20–44 Years	—	43.12	**54.81**
Maternity—Discharges/1,000 Member Years—45–64 Years	—	0.64	**0.56**
Maternity—Discharges/1,000 Member Years—Total	—	23.48	**30.03**

HEDIS Measure	MY 2022	MY 2023	SWA
Maternity—Average Length of Stay—10–19 Years	—	2.78	**2.88**
Maternity—Average Length of Stay—20–44 Years	—	2.78	**2.73**
Maternity—Average Length of Stay—45–64 Years	—	4.78	**3.29**
Maternity—Average Length of Stay—Total	—	2.79	**2.75**
Surgery—Days/1,000 Member Years—Less than 1 Year	—	571.55	**463.70**
Surgery—Days/1,000 Member Years—1–9 Years	—	25.02	**33.47**
Surgery—Days/1,000 Member Years—10–19 Years	—	34.62	**32.49**
Surgery—Days/1,000 Member Years—20–44 Years	—	133.18	**106.78**
Surgery—Days/1,000 Member Years—45–64 Years	—	370.27	**356.86**
Surgery—Days/1,000 Member Years—65–74 Years	—	259.16	**393.71**
Surgery—Days/1,000 Member Years—75–84 Years	—	616.49	**944.71**
Surgery—Days/1,000 Member Years—86 Years	—	1,922.33	**584.92**
Surgery—Days/1,000 Member Years—Total	—	154.00	**123.56**
Surgery—Discharges/1,000 Member Years—Less than 1 Year	—	22.30	**19.95**
Surgery—Discharges/1,000 Member Years—1–9 Years	—	3.42	**3.54**
Surgery—Discharges/1,000 Member Years—10–19 Years	—	4.64	**4.35**
Surgery—Discharges/1,000 Member Years—20–44 Years	—	14.90	**14.26**
Surgery—Discharges/1,000 Member Years—45–64 Years	—	42.51	**42.97**
Surgery—Discharges/1,000 Member Years—65–74 Years	—	40.77	**42.16**
Surgery—Discharges/1,000 Member Years—75–84 Years	—	57.35	**87.74**
Surgery—Discharges/1,000 Member Years—85 Years and Older	—	145.63	**51.79**
Surgery—Discharges/1,000 Member Years—Total	—	16.89	**14.43**
Surgery—Average Length of Stay—Less than 1 Year	—	25.63	**23.24**
Surgery—Average Length of Stay—1–9 Years	—	7.32	**9.44**
Surgery—Average Length of Stay—10–19 Years	—	7.47	**7.46**
Surgery—Average Length of Stay—20–44 Years	—	8.94	**7.49**
Surgery—Average Length of Stay—45–64 Years	—	8.71	**8.31**
Surgery—Average Length of Stay—65–74 Years	—	6.36	**9.34**
Surgery—Average Length of Stay—75–84 Years	—	10.75	**10.77**
Surgery—Average Length of Stay—85 Years and Older	—	13.20	**11.29**
Surgery—Average Length of Stay—Total	—	9.12	**8.56**
Medicine—Days/1,000 Member Years—Less than 1 Year	—	464.15	**414.29**
Medicine—Days/1,000 Member Years—1–9 Years	—	39.66	**40.91**

HEDIS Measure	MY 2022	MY 2023	SWA
Medicine—Days/1,000 Member Years—10–19 Years	—	20.27	**27.72**
Medicine—Days/1,000 Member Years—20–44 Years	—	117.49	**108.57**
Medicine—Days/1,000 Member Years—45–64 Years	—	349.97	**393.48**
Medicine—Days/1,000 Member Years—65–74 Years	—	614.41	**550.81**
Medicine—Days/1,000 Member Years—75–84 Years	—	272.40	**921.88**
Medicine—Days/1,000 Member Years—85 Years and Older	—	2,446.60	**1,617.67**
Medicine—Days/1,000 Member Years—Total	—	142.36	**129.96**
Medicine—Discharges/1,000 Member Years—Less than 1 Year	—	65.78	**75.93**
Medicine—Discharges/1,000 Member Years—1–9 Years	—	9.27	**11.75**
Medicine—Discharges/1,000 Member Years—10–19 Years	—	4.64	**7.45**
Medicine—Discharges/1,000 Member Years—20–44 Years	—	22.06	**23.27**
Medicine—Discharges/1,000 Member Years—45–64 Years	—	62.99	**73.88**
Medicine—Discharges/1,000 Member Years—65–74 Years	—	90.27	**99.37**
Medicine—Discharges/1,000 Member Years—75–84 Years	—	71.68	**158.65**
Medicine—Discharges/1,000 Member Years—85 Years and Older	—	203.88	**164.51**
Medicine—Discharges/1,000 Member Years—Total	—	26.11	**26.76**
Medicine—Average Length of Stay—Less than 1 Year	—	7.06	**5.46**
Medicine—Average Length of Stay—1–9 Years	—	4.28	**3.48**
Medicine—Average Length of Stay—10–19 Years	—	4.37	**3.72**
Medicine—Average Length of Stay—20–44 Years	—	5.33	**4.67**
Medicine—Average Length of Stay—45–64 Years	—	5.56	**5.33**
Medicine—Average Length of Stay—65–74 Years	—	6.81	**5.54**
Medicine—Average Length of Stay—75–84 Years	—	3.80	**5.81**
Medicine—Average Length of Stay—85 Years and Older	—	12.00	**9.83**
Medicine—Average Length of Stay—Total	—	5.45	**4.86**
Total Inpatient—Days/1,000 Member Years—Less than 1 Year	—	1,035.71	**877.99**
Total Inpatient—Days/1,000 Member Years—1–9 Years	—	64.68	**74.37**
Total Inpatient—Days/1,000 Member Years—10–19 Years	—	73.07	**88.24**
Total Inpatient—Days/1,000 Member Years—20–44 Years	—	370.41	**364.98**
Total Inpatient—Days/1,000 Member Years—45–64 Years	—	723.27	**752.20**
Total Inpatient—Days/1,000 Member Years—65–74 Years	—	873.57	**944.52**
Total Inpatient—Days/1,000 Member Years—75–84 Years	—	888.89	**1,866.59**

HEDIS Measure	MY 2022	MY 2023	SWA
Total Inpatient—Days/1,000 Member Years—85 Years and Older	—	4,368.93	**2,202.59**
Total Inpatient—Days/1,000 Member Years—Total	—	348.13	**315.49**
Total Inpatient—Discharges/1,000 Member Years—Less than 1 Year	—	88.07	**95.88**
Total Inpatient—Discharges/1,000 Member Years—1–9 Years	—	12.68	**15.29**
Total Inpatient—Discharges/1,000 Member Years—10–19 Years	—	15.80	**21.53**
Total Inpatient—Discharges/1,000 Member Years—20–44 Years	—	80.08	**92.34**
Total Inpatient—Discharges/1,000 Member Years—45–64 Years	—	106.13	**117.41**
Total Inpatient—Discharges/1,000 Member Years—65–74 Years	—	131.04	**141.53**
Total Inpatient—Discharges/1,000 Member Years—75–84 Years	—	129.03	**246.39**
Total Inpatient—Discharges/1,000 Member Years—85 Years and Older	—	349.51	**216.30**
Total Inpatient—Discharges/1,000 Member Years—Total	—	61.55	**63.75**
Total Inpatient—Average Length of Stay—Less than 1 Year	—	11.76	**9.16**
Total Inpatient—Average Length of Stay—1–9 Years	—	4.63	**4.10**
Total Inpatient—Average Length of Stay—10–19 Years	—	5.10	**4.86**
Total Inpatient—Average Length of Stay—20–44 Years	—	4.63	**3.95**
Total Inpatient—Average Length of Stay—45–64 Years	—	6.81	**6.41**
Total Inpatient—Average Length of Stay—65–74 Years	—	6.67	**6.67**
Total Inpatient—Average Length of Stay—75–84 Years	—	6.89	**7.58**
Total Inpatient—Average Length of Stay—85 Years and Older	—	12.50	**10.18**
Total Inpatient—Average Length of Stay—Total	—	5.66	**4.95**
Enrollment by Product Line			
Less than 1 year	—	2,691	**39,430**
1–4 Years	—	11,152	**154,688**
5–9 Years	—	14,314	**194,614**
10–14 Years	—	12,278	**187,448**
15–17 Years	—	7,821	**113,890**
18–19 Years	—	4,714	**67,190**
20–24 Years	—	11,250	**144,726**
25–29 Years	—	11,619	**119,861**
30–34 Years	—	11,975	**117,909**
35–39 Years	—	10,415	**102,144**

HEDIS Measure	MY 2022	MY 2023	SWA
40–44 Years	—	9,114	**90,116**
45–49 Years	—	7,249	**68,991**
50–54 Years	—	6,982	**61,320**
55–59 Years	—	7,116	**60,505**
60–64 Years	—	7,057	**57,221**
65–69 Years	—	261	**3,396**
70–74 Years	—	86	**1,046**
75–79 Years	—	46	**592**
80–84 Years	—	NA	**421**
85–89 Years	—	NA	**224**
90 Years and Older	—	NA	**173**
Unknown	—	NA	**NA**
Total	—	136,199	**1,585,904**
Language Diversity of Membership			
Spoken Language Preferred for Health Care—Health Plan	—	0.00%	**23.84%**
Spoken Language Preferred for Health Care—CMS/State	—	100.00%	**76.01%**
Spoken Language Preferred for Health Care—Other Third-Party	—	0.00%	**0.15%**
Preferred Language for Written Materials—Health Plan	—	0.00%	**23.78%**
Preferred Language for Written Materials—CMS/State	—	100.00%	**52.79%**
Preferred Language for Written Materials—Other Third-Party	—	0.00%	**23.43%**
Other Language Needs—Health Plan	—	0.00%	**19.20%**
Other Language Needs—CMS/State	—	100.00%	**47.96%**
Other Language Needs—Other Third-Party	—	0.00%	**32.83%**
Spoken Language Preferred for Health Care—Percent English	—	0.00%	**89.10%**
Spoken Language Preferred for Health Care—Percent Non-English	—	0.00%	**1.78%**
Spoken Language Preferred for Health Care—Percent Declined	—	0.00%	**0.00%**
Spoken Language Preferred for Health Care—Percent Unknown	—	100.00%	**9.12%**
Language Preferred for Written Materials—Percent English	—	0.00%	**66.23%**
Language Preferred for Written Materials—Percent Non-English	—	0.00%	**1.37%**
Language Preferred for Written Materials—Percent Declined	—	0.00%	**0.00%**
Language Preferred for Written Materials—Percent Unknown	—	100.00%	**32.40%**

HEDIS Measure	MY 2022	MY 2023	SWA
Other Language Needs—Percent English	—	98.11%	**47.18%**
Other Language Needs—Percent Non-English	—	1.84%	**0.80%**
Other Language Needs—Percent Declined	—	0.00%	**0.00%**
Other Language Needs—Percent Unknown	—	0.06%	**52.02%**
Race/Ethnicity Diversity of Membership			
Race—Health Plan	—	0.00%	**22.17%**
Race—CMS/State	—	66.39%	**56.65%**
Race—Other Direct	—	0.00%	**0.43%**
Race—Direct Total	—	66.39%	**79.25%**
Race—Indirect Total	—	0.00%	**0.61%**
Race—Unknown Total	—	33.61%	**20.14%**
Ethnicity—Health Plan	—	0.00%	**22.63%**
Ethnicity—CMS/State	—	72.75%	**35.49%**
Ethnicity—Other Direct	—	0.00%	**2.20%**
Ethnicity—Direct Total	—	72.75%	**60.32%**
Ethnicity—Indirect Total	—	0.00%	**8.74%**
Ethnicity—Unknown Total	—	27.25%	**30.93%**
Race: White—Ethnicity: Hispanic or Latino	—	0.00%	**0.81%**
Race: White—Ethnicity: Not Hispanic or Latino	—	27.02%	**28.15%**
Race: White—Ethnicity: Asked but No Answer	—	0.00%	**0.02%**
Race: White—Ethnicity: Unknown	—	0.00%	**7.88%**
Race: White—Ethnicity: Total	—	27.02%	**36.87%**
Race: Black or African American—Ethnicity: Hispanic or Latino	—	0.00%	**0.67%**
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	31.94%	**25.38%**
Race: Black or African American—Ethnicity: Asked but No Answer	—	0.00%	**0.03%**
Race: Black or African American—Ethnicity: Unknown	—	0.14%	**11.17%**
Race: Black or African American—Ethnicity: Total	—	32.08%	**37.26%**
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	0.00%	**0.03%**
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	0.55%	**0.48%**

HEDIS Measure	MY 2022	MY 2023	SWA
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	0.00%	**0.21%**
Race: American Indian or Alaska Native—Ethnicity: Total	—	0.55%	**0.72%**
Race: Asian—Ethnicity: Hispanic or Latino	—	0.00%	**0.04%**
Race: Asian—Ethnicity: Not Hispanic or Latino	—	0.00%	**1.58%**
Race: Asian—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Asian—Ethnicity: Unknown	—	6.61%	**1.02%**
Race: Asian—Ethnicity: Total	—	6.61%	**2.64%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	—	0.03%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	0.03%	**0.02%**
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	0.00%	**0.15%**
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.68%**
Race: Some Other Race—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Some Other Race—Ethnicity: Unknown	—	0.11%	**1.19%**
Race: Some Other Race—Ethnicity: Total	—	0.11%	**2.02%**
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	0.00%	**0.14%**
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.02%**
Race: Two or More Races—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Two or More Races—Ethnicity: Unknown	—	0.00%	**0.16%**
Race: Two or More Races—Ethnicity: Total	—	0.00%	**0.33%**
Race: Unknown—Ethnicity: Hispanic or Latino	—	1.63%	**0.83%**
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	0.46%	**7.38%**
Race: Unknown—Ethnicity: Asked but No Answer	—	11.14%	**2.65%**
Race: Unknown—Ethnicity: Unknown	—	20.37%	**9.27%**
Race: Unknown—Ethnicity: Total	—	33.61%	**20.14%**
Race: Total—Ethnicity: Hispanic or Latino	—	1.63%	**2.67%**

HEDIS Measure	MY 2022	MY 2023	SWA
Race: Total—Ethnicity: Not Hispanic or Latino	—	59.97%	**63.68%**
Race: Total—Ethnicity: Asked but No Answer	—	11.14%	**2.71%**
Race: Total—Ethnicity: Unknown	—	27.25%	**30.93%**
Race: Total—Ethnicity: Total	—	100.00%	**100.00%**
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Unknown	—	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Total	—	0.00%	**0.00%**

* Indicates a lower rate is desirable.
Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.
For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.
— is presented for measures that were not reported by the MCOs in MY 2022 and indicates that MY 2022 rates are not available for those measures.

Table 3-5—ABH HEDIS Performance Measure Summary—MY 2022 and MY 2023 Comparison

Measure Status	MY 2022	MY 2023*
≥ NCQA National 50th Percentile Benchmark	20	163
< NCQA National 50th Percentile Benchmark	58	113
NCQA National Benchmark Unavailable	11	12
Total	89	288

* The "Total" row presents the count of all HEDIS measure indicators that could be reported by ABH for MY 2023, excluding indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NB* (i.e., MCO did not provide the health benefit), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator). The "≥ NCQA National 50th Percentile Benchmark," "< NCQA National 50th Percentile Benchmark," and "NCQA National Benchmark Unavailable" rows present the count of indicators with reportable rates, for each MCO, that met the comparison criteria. For MY 2023, measure indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator) are excluded from the comparison rows because their results are not comparable to NCQA benchmarks.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- ABH's rate on the *Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen (Total)* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH was effective in coordinating with providers to ensure adolescent and adult Medicaid members had timely follow-up care after a positive depression screen. **[Quality]**
- ABH's rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH was effective in ensuring that adult members on antipsychotics were screened for diabetes and had their diabetes monitored, resulting in positive health outcomes for this population. **[Quality]**
- ABH's rate on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH was effective in ensuring that adult members with cardiovascular disease and schizophrenia had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- ABH's rate on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH effectively coordinated with providers to ensure blood glucose testing was conducted for child and adolescent members on antipsychotics. **[Quality]**
- ABH's rate on the *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH was effective in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- ABH's rate on the following *Childhood Immunization Status* measure indicators was above the NCQA national 50th percentile benchmark for MY 2023: *IPV*, *HiB*, *Hepatitis B*, and *VZV*. This result suggests that ABH was effective in ensuring that children 2 years of age were receiving some immunizations to help protect them against a potential life-threatening disease. **[Quality and Access]**
- ABH's rate on the following *Immunizations for Adolescents* measure indicators was above the NCQA national 50th percentile benchmark for MY 2023: *HPV* and *Combination 2*. This result suggests that ABH was effective in ensuring that adolescent members were receiving immunizations to help protect them against meningococcal disease, tetanus, diphtheria, pertussis, and HPV. **[Quality]**
- ABH's rate on the *Colorectal Cancer Screening* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH was effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- ABH's rate on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**

- ABH's rates on the *Statin Therapy for Patients With Cardiovascular Disease* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ABH effectively coordinated with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) received statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- ABH's rate on the *HbA1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH effectively coordinated with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- ABH's rate on the *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH effectively coordinated with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- ABH's rates on the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* and *Engagement of SUD Treatment* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ABH effectively coordinated with providers to initiate treatment for members with a new SUD episode and engaged these members in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment. **[Quality, Timeliness, and Access]**
- ABH's rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH effectively coordinated with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- ABH's rate on the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH effectively coordinated with providers to ensure that children prescribed ADHD medication participated in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**
- ABH's rate on the *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH effectively coordinated with providers to ensure adult members diagnosed with major depression were prescribed antidepressant medication and remained on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**
- ABH's rates on the following *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *5–11 Years*, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*. These results suggest that ABH effectively coordinated with providers to help members with persistent asthma manage this treatable condition. **[Quality]**
- ABH's rates on the *Well-Child Visits in the First 30 Months of Life—First 15 Months* and *15 Months–30 Months* measure indicators were above the NCQA national 50th percentile benchmark

for MY 2023. These results suggest that ABH effectively coordinated with PCPs to ensure that children were seen within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**

For ABH, the following opportunities for improvement were identified:

- ABH's rates on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ABH has room for improvement in its coordination with providers to ensure that members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. **[Quality, Timeliness, and Access]**

  ABH's rates on the *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. Additionally, ABH's rates on the *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ABH has room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**
- ABH's rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- ABH's rate on the *Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening (Total)* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in coordinating with providers to ensure adolescent and adult Medicaid members are properly screened for depression to enable timely follow-up care. **[Quality]**
- ABH's rate on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement with ensuring that adult members on antipsychotics are screened for diabetes and have their diabetes monitored to promote positive health outcomes for this population. **[Quality]**
- ABH's rates on the following *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *Cholesterol Testing* and *Blood Glucose and Cholesterol Testing*. These results suggest that ABH has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- ABH'S rates on the following *Childhood Immunization Status* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *DTaP*, *MMR*, *Pneumococcal Conjugate*, *Hepatitis A*, *Rotavirus, Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*. These results

suggest that ABH has room for improvement in coordinating with providers to ensure children under 2 years of age are receiving all appropriate vaccinations to protect them against potential life-threatening diseases. **[Quality and Access]**

- ABH's rates on the following *Immunizations for Adolescents* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *Meningococcal*, *Tdap/Td*, and *Combination 1*. This result suggests that ABH has room for improvement with ensuring that adolescent members are receiving all appropriate immunizations to help protect them against potential life-threatening diseases. **[Quality]**
- ABH's rates on the following *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *BMI Percentile Documentation*, *Counseling for Nutrition*, and *Counseling for Physical Activity*. These results suggest that ABH has room for improvement in its coordination with providers to ensure that child and adolescent members are having their weight and BMI monitored, and are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- ABH's rate on the *HbA1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in its coordination with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- ABH's rate on the *Eye Exam for Patients With Diabetes* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in its coordination with providers to ensure that adult members with diabetes receive a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- ABH's rate on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- ABH's rate on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- ABH's rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder are dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- ABH's rate on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in coordinating with providers to initiate appropriate follow-up visits for children prescribed ADHD medication. **[Quality, Timeliness, and Access]**

- ABH's rate on the *Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in coordinating with providers to treat adult members diagnosed with major depression with antidepressant medication and help members remain on antidepressant medication for at least 84 days (Acute Phase). **[Quality]**
- ABH's rate on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement with ensuring that a diagnosis of upper respiratory infection (URI) does not result in an antibiotic dispensing event for members. **[Quality]**
- ABH's rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- ABH's rate on the *Use of Imaging Studies for Low Back Pain* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- ABH's rate on the *Non-Recommended Cervical Screening in Adolescent Females* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement with ensuring that providers avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- ABH's rate on the *Cervical Cancer Screening* measure was below the NCQA national 50th percentile benchmark for MY 2023. This result suggests that ABH has room for improvement in coordinating with providers to ensure that women ages 21 to 64 years receive appropriate, early detection cancer screening. **[Quality]**
- ABH's rates on the following *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *20–44 Years*, *45–64 Years*, *65 Years and Older*, and *Total*. These results suggest that ABH has room for improvement in coordinating with PCPs to ensure that adult members are engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- ABH's rates on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that ABH has room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care, in alignment with guidance provided by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**
- ABH's rates on the following *Child and Adolescent Well-Care Visits* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *3–11 Years*, *12–17 Years*, and *18–21 Years*. These results suggest that ABH has room for improvement in coordinating with providers to ensure that adolescents receive appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For ABH, the following recommendations were identified:

- To improve performance on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, and *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators, HSAG recommends that ABH work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and ABH. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**
- To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommends that ABH work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening (Total)* measure indicator, HSAG recommends that ABH work with providers to identify and address barriers preventing Medicaid members from receiving a depression screen. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure, HSAG recommends that ABH work with providers to identify and address barriers preventing members on antipsychotics from receiving diabetes screening and monitoring services. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators, HSAG recommends that ABH work with providers to identify root causes and trial interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**
- To improve performance on the *Childhood Immunization Status* measure indicators, HSAG recommends that ABH focus its efforts on increasing immunizations for children. ABH should also consider conducting a root cause analysis and implementing appropriate interventions to improve performance that are evidence-based and address barriers such as parent dissatisfaction, provider capacity, or appointment accessibility. Additionally, ABH should consider inclusion of parent/guardian and provider participation when evaluating root causes of measure performance. **[Quality and Access]**
- To improve performance on the *Immunizations for Adolescents* measure indicators, HSAG recommends that ABH focus its efforts on increasing immunizations for adolescents. ABH should also consider conducting a root cause analysis and implementing appropriate interventions to improve performance that are evidence-based and address barriers such as parent dissatisfaction, provider capacity, or appointment accessibility. ABH should also consider inclusion of

parent/guardian and provider participation when evaluating root causes of measure performance. **[Quality]**

- To improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, HSAG recommends that ABH work with PCPs to identify and address barriers to primary care visits for children and adolescents in need of weight assessment and education on healthy habits. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality]**
- To improve performance on the *HbA1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)* measure indicator, HSAG recommends that ABH work with providers to identify and address barriers to effective blood glucose control among members with diabetes. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions such as patient and provider education and outreach campaigns. **[Quality]**
- To improve performance on the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that ABH work with providers to identify and address barriers to retinal eye exams for members with diabetes. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education and outreach campaigns. **[Quality]**
- To improve performance on the *Controlling High Blood Pressure* measure, HSAG recommends that ABH work with providers to identify and address barriers to effective blood pressure management in members. ABH could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure, HSAG recommends that ABH work with providers to identify and address barriers to effective blood pressure management for diabetic members. ABH could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that ABH work with providers to identify and address

barriers to the dispensing of antipsychotic medications to members with schizophrenia or schizoaffective disorder, and barriers to adherence to antipsychotic medications. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as provider education on the importance of medication adherence. **[Quality]**

- To improve performance on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator, HSAG recommends that ABH work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as provider education on the importance of medication adherence. **[Quality, Timeliness, and Access]**
- To improve performance on the *Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator, HSAG recommends that ABH work with providers to identify and address barriers to prescribing antidepressant medication to adult members with major depression. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, HSAG recommends that ABH work with providers to trial solutions to reduce antibiotic dispensing to treat URI. ABH could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, HSAG recommends that ABH work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. ABH could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that ABH focus its efforts on decreasing unnecessary imaging for low back pain. HSAG recommends that ABH work with providers to trial solutions to reduce the inappropriate ordering of imaging studies. **[Quality]**
- To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommends that ABH work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- To improve performance on the *Cervical Cancer Screening* measure, HSAG recommends that ABH work with providers to identify and address barriers to cervical cancer screening for women ages 21 to 64 years old. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as offering screenings at more locations or expanding clinic and screening hours. **[Quality]**
- To improve performance on the *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, HSAG recommends that ABH work with PCPs to identify and address barriers to

preventive or ambulatory visits for adult members. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**

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

Methodology

Objectives

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

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

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

Technical Methods of Data Collection

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[3-1] specifies that, in lieu of conducting a full on-site Information Systems Capabilities Assessment (ISCA), the EQRO may review an assessment of the MCO's IS conducted by another party. If an MCO is accredited by NCQA, the MCO will have received a full IS assessment as part of its annual HEDIS Compliance Audit by an NCQA HEDIS Compliance Audit licensed organization (LO). In this case, HSAG would request and review the MCO's NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap), FAR, and the data submission tool in lieu of conducting an on-site assessment.

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

HEDIS Measure Validation

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

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

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

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

Non-HEDIS Measure Validation

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

In accordance with the MY 2023 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. For each HEDIS measure, the MCO was evaluated on how its rate compared to the NCQA Quality Compass MY 2023 national 50th percentile Medicaid HMO benchmark.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the MY 2023 performance levels based on comparison to the NCQA national 50th percentile benchmark percentile to identify strengths and opportunities for improvement and determine whether each strength and opportunity for improvement impacted one or more of the domains of quality, timeliness, or access. Additionally, for each opportunity for improvement, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCO's Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-6. The measures marked *NA* are related to utilization of services.

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

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

Performance Measure	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Ambulatory Care—Outpatient Visits/1,000 Member Years and *Emergency Department Visits/1,000 Member Years*	NA	NA	NA
Plan All-Cause Readmissions—Observed Readmissions, *Expected Readmissions*, and *O/E Ratio*	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Flu Vaccinations for Adults Ages 18 to 64	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation, *Counseling for Nutrition*, and *Counseling for Physical Activity*	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total and *Statin Adherence 80%—Total*	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Eye Exam for Patients With Diabetes	✓		
Pharmacotherapy for Opioid Use Disorder	✓		
Initiation and Engagement of SUD Treatment—Initiation of SUD and *Engagement of SUD*	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		

Performance Measure	Quality	Timeliness	Access
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Non-Recommended Cervical Screening in Adolescent Females	✓		
Depression Screening and Follow-Up for Adolescents and Adults	✓		
Asthma Medication Ratio—5–11 Years, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*	✓		
Topical Fluoride for Children—1–2 Years, *3–4 Years*, and *Total*			
Oral Evaluation, Dental Services —0–2 Years, *3–5 Years*, *6–14 Years*, *15–20 Years*, and *Total*			
Use of Imaging Studies for Low Back Pain	✓		
Inpatient Utilization—General Hospital/Acute Care—Maternity, *Surgery*, *Medicine*, and *Total Inpatient*	NA	NA	NA
Enrollment by Product Line	NA	NA	NA
Language Diversity of Membership	NA	NA	NA
Race/Ethnicity Diversity of Membership	NA	NA	NA

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

Federal regulations require the MCOs to undergo a CR at least once every three years to determine compliance with federal standards. Table 4-1 delineates the CR standards that were reviewed during the current three-year CR cycle, along with scores for ABH.

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

Standard Name	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Enrollment and Disenrollment[2]		**42.9%[2]**	
Member Rights and Confidentiality	93.0%		
Member Information			
Coverage and Authorization of Services	98.5%		
Emergency and Post-Stabilization Services			
Availability of Services	99.2%		
Assurances of Adequate Capacity and Services	100%		
Coordination and Continuity of Care	91.6%		
Provider Selection	97.8%		
Subcontractual Relationships and Delegation	100%		
Practice Guidelines	100%		
Health Information Systems	100%		
Quality Assessment and Performance Improvement Program	98.6%		
Grievance and Appeal Systems	100%		
Program Integrity	95.8%		

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

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

Follow-Up on Previous Compliance Review Findings

Following the year two CR, HSAG worked with LDH to issue CAPs for elements in Standard I—Enrollment and Disenrollment that were not compliant. The MCOs were required to submit the CAP for approval. Upon approval from LDH and HSAG, the MCOs were required to implement the CAP and

submit evidence of implementation. HSAG worked with LDH to review, approve, and monitor CAPs during SFY 2023.

ABH achieved compliance in six of six elements from the 2023 CAPs, demonstrating positive improvements in implementing CAPs from 2023.

HSAG will conduct a comprehensive CR during 2025 to determine the extent to which the MCOs are in compliance with federal standards.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- ABH successfully remediated all six elements, indicating that initiatives were implemented and demonstrated compliance with the requirements under review. **[Quality, Timeliness, and Access]**

For ABH, the following opportunities for improvement were identified:

- HSAG did not identify any opportunities for improvement.

For ABH, the following required actions and recommendations were identified:

- HSAG did not identify any required actions or recommendations.

Methodology

Standards

Table 4-2 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In year three (CY 2023), HSAG conducted a follow-up review of each MCO's CAPs from the previous CRs. HSAG will conduct a comprehensive CR during CY 2025 to determine the extent to which the MCOs are in compliance with federal standards during the review period CY 2024.

Table 4-2—Summary of CR Standards

Standard	Year One (CY 2021)			Year Two (CY 2022)			Year Three (CY 2023)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment				✓	✓	✓			
Standard II—Member Rights and Confidentiality	✓	✓	✓						
Standard III—Member Information	✓	✓	✓						
Standard IV—Emergency and Poststabilization Services	✓	NA				✓			
Standard V—Adequate Capacity and Availability of Services	✓	✓	✓						
Standard VI—Coordination and Continuity of Care	✓	✓	✓						
Standard VII—Coverage and Authorization of Services	✓	✓	✓						
Standard VIII—Provider Selection	✓	✓	✓						
Standard IX—Subcontractual Relationships and Delegation	✓		✓		✓				
Standard X—Practice Guidelines	✓	✓	✓						
Standard XI—Health Information Systems	✓	✓	✓						
Standard XII—Quality Assessment and Performance Improvement Program	✓	✓	✓						
Standard XIII—Grievance and Appeal Systems	✓	✓	✓						
Standard XIV—Program Integrity	✓	✓	✓						
CAP Review							✓	✓	✓

NA=not applicable for the PAHPs

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table 4-3 describes the standards and associated regulations and requirements reviewed for each standard.

Table 4-3—Summary of CR Standards and Associated Regulations

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

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

Objectives

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

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

Technical Methods of Data Collection

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

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

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

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

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

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

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

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

Results

Provider Directory Accuracy

HSAG conducted PDV reviews from July 2023 through November 2023 (review period). This section presents the results from the CY 2023 PDV for all sampled ABH providers by specialty type across all four quarters.

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

Table 5-1—Response Rate and Indicator Match Rates for ABH by Specialty Type

Specialty Type	Response Rate		Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**409**	**81.8%**	**274**	**67.0%**	**272**	**66.5%**	**233**	**57.0%**	**231**	**56.5%**	**225**	**55.0%**	**250**	**61.1%**
Internal Medicine/ Family Medicine	81	81.0%	57	70.4%	54	66.7%	38	46.9%	46	56.8%	44	54.3%	50	61.7%
Pediatrics	93	93.0%	62	66.7%	78	83.9%	65	69.9%	71	76.3%	71	76.3%	74	79.6%
OB/GYN	81	81.0%	44	54.3%	50	61.7%	45	55.6%	45	55.6%	45	55.6%	46	56.8%
Specialists (any)	82	82.0%	58	70.7%	49	59.8%	47	57.3%	33	40.2%	33	40.2%	46	56.1%
Behavioral Health (any)	72	72.0%	53	73.6%	41	56.9%	38	52.8%	36	50.0%	32	44.4%	34	47.2%

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

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

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**500**	**122**	**34.8%**
Internal Medicine/Family Medicine	100	21	35.0%
Pediatrics	100	40	54.3%

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
OB/GYN	100	22	35.0%
Specialists (any)	100	19	24.3%
Behavioral Health (any)	100	20	25.3%

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

Table 5-3 presents ABH's reasons for noncompliance.

Table 5-3—Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**378**	**75.6%**
Total reasons for noncompliance[1]	**441**	**NA**
Provider does not participate with MCO or Louisiana Medicaid	48	9.6%
Provider is not at site	107	21.4%
Provider not accepting new patients	22	4.4%
Wrong telephone number	4	0.8%
No response/busy signal/disconnected telephone number (after three calls)	85	17.0%
Representative does not know	1	0.2%
Incorrect address reported	116	23.2%
Address (suite number) needs to be updated	19	3.8%
Wrong specialty reported	39	7.8%

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.
NA = a rate was not calculated for this element.

Provider Access Surveys

HSAG conducted provider access surveys in September 2023 and November to December 2023 (review period). This section presents the results from the CY 2023 provider access surveys for all sampled providers by MCO and specialty type.

Table 5-4 illustrates the response rate and indicator match rates for ABH by specialty type.

Table 5-4—Response Rate and Indicator Match Rates for ABH by Specialty Type

Specialty Type	Response Rate		Correct Address		Offered Requested Services		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients		Provider at Location	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**146**	**77.7%**	**130**	**89.0%**	**72**	**49.3%**	**63**	**43.2%**	**56**	**38.4%**	**51**	**34.9%**	**32**	**21.9%**
Primary Care	44	73.3%	41	93.2%	28	63.6%	23	52.3%	20	45.5%	18	40.9%	8	18.2%
Pediatrics	30	75.0%	26	86.7%	8	26.7%	7	23.3%	6	20.0%	5	16.7%	3	10.0%
OB/GYNs	17	85.0%	16	94.1%	12	70.6%	12	70.6%	12	70.6%	12	70.6%	8	47.1%
Endocrinologists	10	83.3%	9	90.0%	6	60.0%	4	40.0%	4	40.0%	3	30.0%	2	20.0%
Dermatologists	14	77.8%	13	92.9%	10	71.4%	10	71.4%	8	57.1%	7	50.0%	6	42.9%
Neurologists	17	85.0%	15	88.2%	2	11.8%	2	11.8%	2	11.8%	2	11.8%	2	11.8%
Orthopedic Surgeons	14	77.8%	10	71.4%	6	42.9%	5	35.7%	4	28.6%	4	28.6%	3	21.4%

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

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

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Routine Primary Care Visit	5	100%
Routine Pediatric Visit	6	100%
Non-Urgent Sick Primary Care Visit	13	40.0%
Non-Urgent Sick Pediatric Visit	5	0.0%
OB/GYN Visit	17	50.0%
Endocrinologist Visit	NA	NA

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Dermatologist Visit	7	100%
Neurologist Visit	NA	NA
Orthopedic Surgeon Visit	12	100%

NA indicates that cases responding to the survey did not offer a new patient appointment date.

Table 5-6 presents ABH's provider access survey weighted compliance scores by specialty type. Please see the network adequacy validation (NAV) methodology for the weighted compliance score calculation criteria.

Table 5-6—Provider Access Survey Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**188**	**32**	**40.4%**
Primary Care	60	8	29.4%
Pediatrics	40	3	40.8%
OB/GYNs	20	8	55.0%
Endocrinologists	12	2	36.1%
Dermatologists	18	6	46.3%
Neurologists	20	2	56.7%
Orthopedic Surgeons	18	3	38.9%

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

Table 5-7 presents ABH's provider access survey reasons for noncompliance.

Table 5-7—Provider Access Survey Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**156**	**83.0%**
Total reasons for noncompliance[1]	**158**	**NA**
Provider does not participate with MCO or Louisiana Medicaid	16	8.5%
Provider is not at site	19	10.1%
Provider not accepting new patients	5	2.7%
Wrong telephone number	2	1.1%

Reason	Count	Rate (%)
No response/busy signal/disconnected telephone number (after three calls)	40	21.3%
Incorrect address reported	16	8.5%
Address (suite number) needs to be updated	2	1.1%
Wrong specialty reported	58	30.9%

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.
NA = a rate was not calculated for this element.

Table 5-8 presents ABH's provider access survey after-hours weighted compliance scores by specialty type.

Table 5-8—Provider Access Survey After-Hours Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**45**	**6**	**15.6%**
Primary Care	15	3	22.2%
Pediatrics	10	1	10.0%
OB/GYNs	5	2	46.7%
Endocrinologists	2	0	16.7%
Dermatologists	4	0	0.0%
Neurologists	5	0	0.0%
Orthopedic Surgeons	4	0	0.0%

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

NAV Audit

This section presents the results from the CY 2023 (review period) NAV audit.

Based on the NAV audit combined with the virtual review and detailed validation of each indicator, HSAG determined that ABH achieved a *High Confidence* validation rating, with the exception of indicators resulting in an *Unable to Validate* designation, which refers to HSAG's overall confidence that ABH used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Table 5-9 contains the percentage of members ABH reported with access at the statewide level, by provider type and by urbanicity. LDH established a 100 percent threshold for MCOs when determining

requirements met with distance standards. Results that achieved the 100 percent threshold are shaded green. Items marked "NA" indicate provider types for which results were unavailable due to misalignment between instructions within the LDH-provided reporting template, which did not include a requirement to provide results for the applicable indicator.

Table 5-9—ABH Distance Requirements Met by Percentage of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity	Percentage of Members With Access
Adult PCP (Family/General Practice; Internal Medicine and Physician Extenders*)	Urban	98.7%
	Rural	100%
Pediatrics (Family/General Practice; Internal Medicine and Physician Extenders*)	Urban	98.9%
	Rural	100%
Federally Qualified Health Centers (FQHCs)	Urban	91.8%
	Rural	99.8%
RHCs	Urban	75.1%
	Rural	100%
Acute Inpatient Hospitals	Urban	88.9%
	Rural	99.9%
Laboratory	Urban	92.7%
	Rural	62.5%
Radiology	Urban	98.1%
	Rural	93.4%
Pharmacy	Urban	98.2%
	Rural	100%
Hemodialysis Centers	Urban	90.2%
	Rural	95.2%
Home Health	Urban	NA
	Rural	NA
OB/GYNs (access only for adult female members)	Urban	97.2%
	Rural	95.5%
Allergy/Immunology	Urban	96.7%
	Rural	86.3%

Provider Type	Urbanicity	Percentage of Members With Access
Cardiology	Urban	99.9%
	Rural	100%
Dermatology	Urban	99.3%
	Rural	89.0%
Endocrinology and Metabolism (Adult)	Urban	99.8%
	Rural	95.9%
Endocrinology and Metabolism (Pediatric)	Urban	99.7%
	Rural	96.2%
Gastroenterology	Urban	99.9%
	Rural	99.9%
Hematology/Oncology	Urban	97.0%
	Rural	91.8%
Nephrology	Urban	96.7%
	Rural	98.6%
Neurology (Adult)	Urban	99.9%
	Rural	100%
Neurology (Pediatric)	Urban	99.9%
	Rural	100%
Ophthalmology	Urban	99.9%
	Rural	100%
Orthopedics (Adult)	Urban	99.9%
	Rural	100%
Orthopedics (Pediatric)	Urban	99.9%
	Rural	100%
Otorhinolaryngology/Otolaryngology	Urban	99.9%
	Rural	100%
Urology	Urban	99.9%
	Rural	99.7%
Other Specialty Care	Urban	NA
	Rural	NA
Psychiatrists	Urban	96.7%
	Rural	97.3%

Provider Type	Urbanicity	Percentage of Members With Access
Physicians and Licensed Mental Health Professional (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders	Urban	89.3%
	Rural	71.1%
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders	Urban	89.3%
	Rural	71.1%
Behavioral Health Specialist (Other Specialty Care: APRN-BH specialty, Licensed Psychologist or LCSW)	Urban	99.3%
	Rural	100%
PRTFs, PRTF (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21)	Urban	100%
	Rural	NA
American Society of Addiction Medicine (ASAM) Level 1	Urban	92.7%
	Rural	90.3%
ASAM Level 2.1	Urban	93.3%
	Rural	86.9%
ASAM Level 2 WM	Urban	86.4%
	Rural	79.6%
ASAM Level 3.1 (Adult over age 21)	Urban	80.2%
	Rural	33.8%
ASAM Level 3.1 (Pediatric under age 21)	Urban	95.2%
	Rural	NA
ASAM Level 3.2 WM (Adult over age 21)	Urban	77.1%
	Rural	64.4%
ASAM Level 3.2 WM (Pediatric under age 21)	Urban	76.2%
	Rural	NA
ASAM Level 3.3 (Adult over age 21)	Urban	82.9%
	Rural	42.5%
ASAM Level 3.5 (Adult over age 21)	Urban	68.7%
	Rural	43.6%
ASAM Level 3.5 (Pediatric under age 21)	Urban	88.9%
	Rural	NA

Provider Type	Urbanicity	Percentage of Members With Access
ASAM Level 3.7 (Adult over age 21)	Urban	94.7%
	Rural	79.9%
ASAM Level 3.7 WM	Urban	93.8%
	Rural	74.2%
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	100%
	Rural	100%
Mental Health Rehabilitation Agency (Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention—Mental Health Rehabilitation Agency [Legacy MHR], Behavioral Health Rehab Provider Agency [Non-Legacy MHR]; Mental Health Clinics	Urban	94.7%
	Rural	81.6%

* Physician Extenders: Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services to adults.

HSAG assessed ABH's results for combined adult PCP and combined pediatrics provider-to-member ratios at the statewide level. The statewide level consists of nine LDH regions, which indicated ABH's statewide results exceeded LDH-established requirements. Table 5-10 displays the statewide combined adult PCP and combined pediatrics provider-to-member ratios.

Table 5-10—ABH Statewide Combined Adult PCP and Combined Pediatrics Provider-to-Member Ratios

Provider Type	Indicator
Adult PCPs—Physicians Full-Time Employees (FTEs)	Adult PCPs—Physicians (FTEs) (1:1,000 members)
Family/General Practice (that agree to full PCP responsibility)	
Internal Medicine (that agree to full PCP responsibility)	
FQHCs	
RHCs	
Adult PCP Physician Extenders (Equivalent to 0.5 PCP FTE)	Adult PCP Physician Extenders (FTEs) (1:1,000 members equivalent to 0.5 PCP FTE)
Nurse practitioners (that agree to full PCP responsibility)	
Certified nurse mid-wives (that agree to full PCP responsibility)	

Provider Type	Indicator
Physician assistants linked to a physician group (that agree to full PCP responsibility)	
Pediatric PCPs—Physicians (FTEs)	Pediatric PCPs—Physicians (FTEs) (1:1,000 members)
Family/General Practice (that agree to full PCP responsibility)	
Internal Medicine (that agree to full PCP responsibility)	
FQHCs	
RHCs	
Pediatric PCP Physician Extenders (Equivalent to 0.5 PCP FTE)	Pediatric PCP Physician Extenders (FTEs) (1:1,000 members equivalent to 0.5 PCP FTE)
Nurse practitioners (that agree to full PCP responsibility)	
Certified nurse mid-wives (that agree to full PCP responsibility)	
Physician assistants linked to a physician group (that agree to full PCP responsibility)	
Statewide Combined Ratio	
Combined Adult PCP FTEs (1:1,000 adult members)	1.69%
Combined Pediatrics (1:1,000 adult members)	5.46%

HSAG assessed ABH's results for statewide provider-to-member ratios by specialty provider type and determined that ABH's statewide results met or exceeded LDH-established requirements. Table 5-11 displays the statewide provider-to-member ratios by provider type and indicator.

Table 5-11—ABH Statewide Provider-to-Member Ratio by Specialty Provider Type

Specialty Care	Indicator	Statewide Ratio
OB/GYN	1:10,000 (0.01%)	0.25%
Allergy/Immunology	1:100,000 (0.001%)	0.02%
Cardiology	1:20,000 (0.005%)	0.17%
Dermatology	1:40,000 (0.003%)	0.06%
Endocrinology and Metabolism	1:25,000 (0.004%)	0.03%
Gastroenterology	1:30,000 (0.003%)	0.10%

Specialty Care	Indicator	Statewide Ratio
Hematology/Oncology	1:80,000 (0.001%)	0.02%
Nephrology	1:50,000 (0.002%)	0.02%
Neurology	1:35,000 (0.003%)	0.11%
Ophthalmology	1:20,000 (0.005%)	0.13%
Orthopedics	1:15,000 (0.007%)	0.16%
Otorhinolaryngology/Otolaryngology	1:30,000 (0.003%)	0.10%
Urology	1:30,000 (0.003%)	0.07%

HSAG assessed ABH's results for behavioral health providers to determine the accessibility and availability of appointments and determined that ABH met all LDH-established performance goals for three reported appointment access standards. Table 5-12 displays the performance measure, threshold, LDH-established performance goal, and achieved compliance rate.

Table 5-12—ABH Appointment Access Standards Compliance Rate for Behavioral Health

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	100%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	99%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	100%

During the NAV review period, HSAG determined the access/timeliness standards in Table 5-13 were not included in the LDH-required reporting templates, resulting in an *Unable to Validate* validation rating for each associated indicator.

Table 5-13—ABH Access and Timeliness Standards Unable to Validate

Type of Visit/Admission/Appointment	Access/Timeliness Standard
Urgent Non-Emergency Care	24 hours, 7 days/week within 24 hours of request
Non-Urgent Sick Primary Care	72 hours
Non-Urgent Routine Primary Care	6 weeks
After Hours, by Phone	Answer by live person or call back from a designated medical practitioner within 30 minutes
OB/GYN Care for Pregnant Women:	
1st Trimester	14 days

Type of Visit/Admission/Appointment	Access/Timeliness Standard
2nd Trimester	7 days
3rd Trimester	3 days
High-Risk Pregnancy, Any Trimester	3 days
Family Planning Appointments	1 week
Specialist Appointments	1 month
Scheduled Appointments	Less than a 45-minute wait in office
Psychiatric Inpatient Hospital (Emergency Involuntary)	4 hours
Psychiatric Inpatient Hospital (Involuntary)	24 hours
Psychiatric Inpatient Hospital (Voluntary)	24 hours
ASAM Levels 3.3, 3.5, and 3.7	10 business days
Residential WM	24 hours when medically necessary
PRTF	20 calendar days

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- ABH had a strong provider network and demonstrated the importance of building strong partnerships with its providers to improve quality at a lower cost by aligning financial incentives. As of December 31, 2023, 97 percent of PCPs participated in value-based payment arrangements. **[Quality, Timeliness, and Access]**
- ABH was the fastest growing health plan since December 2022 and has more than doubled its enrollment (from 65,000 to over 146,000) members since it first started in 2015. **[Quality, Timeliness, and Access]**
- No strengths were identified in the PDV activity, as all indicators had match rates below 90 percent.
- Of the cases that offered an appointment date in the provider access survey, 100 percent of routine primary care, routine pediatric, dermatology, and orthopedic surgeon cases offered an appointment within the compliance standard. **[Timeliness and Access]**

For ABH, the following opportunities for improvement were identified:

- In review of ABH distance results, HSAG observed that ABH did not adhere to LDH reporting requirements, which require all specialties to be reported based on distance and urbanicity. ABH did not report percentages based on urbanicity for a subset of specialty providers.
- HSAG recommends that ABH review the reporting requirements set forth by LDH to ensure alignment with the required LDH requirements. **[Quality, Timeliness, and Access]**

- Acceptance of Louisiana Medicaid was inaccurate with 55.0 percent of providers in the PDV and 38.4 percent of locations in the provider access survey accepting Louisiana Medicaid. **[Quality and Access]**
- Acceptance of ABH was inaccurate with 56.5 percent of providers in the PDV and 43.2 percent of locations in the provider access survey accepting ABH. **[Quality and Access]**
- Overall, only 57.0 percent of providers in the PDV and 49.3 percent of locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**
- Overall, acceptance of new patients was relatively low with 61.1 percent of providers in the PDV and 34.9 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 66.5 percent of PDV locations and 21.9 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Of the cases that offered an appointment, 50.0 percent of OB/GYN cases, 40.0 percent of non-urgent sick primary care cases, and 0.0 percent of non-urgent sick pediatric cases were within the wait time compliance standards. Additionally, endocrinology and neurology cases did not offer any new patient appointment dates. **[Timeliness and Access]**
- Compliance scores varied by survey type with an overall compliance score of 34.8 percent for the PDV, 40.4 percent for the provider access survey, and 15.6 percent for the after-hours provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with specialists having the lowest compliance score at 24.3 percent and pediatrics having the highest compliance score at 54.3 percent for the PDV. For the provider access survey, primary care exhibited the lowest compliance score at 29.4 percent and neurologists exhibited the highest compliance score at 56.7 percent. While dermatologists, neurologists, and orthopedic surgeons exhibited the lowest compliance score at 0.0 percent, OB/GYNs exhibited the highest compliance score at 46.7 percent for the after-hours provider access survey. **[Quality and Access]**

For ABH, the following recommendations were identified:

- LDH should provide ABH with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which ABH will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). **[Quality and Access]**
- In addition to updating provider information, ABH should conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent. **[Quality and Access]**
- ABH should consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care. **[Timeliness and Access]**

Methodology

Objectives

The purpose of NAV activities is to evaluate the sufficiency of the provider network as reported by the MCO, ensure the sufficiency of the network to provide adequate access to all services covered under the contract for all members, and provide recommendations to address network deficiencies.
In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, and PAHPs, collectively referred to as "MCEs," are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

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

Technical Methods of Data Collection

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

Provider Directory Validation

HSAG conducted PDV reviews from July 2023 through November 2023. To conduct the NAV analysis, HSAG utilized the MCOs' online provider directories to locate and extract provider data elements. Trained interviewers collected survey responses using a standardized script to validate survey indicators pertaining to provider data accuracy, such as telephone number, address, provider specialty, provider

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 17, 2024.

affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance.

Provider Access Survey

HSAG conducted provider access surveys in September 2023 and November to December 2023. To conduct the NAV analysis, each MCO used the data request document prepared by HSAG to identify providers potentially eligible for survey inclusion, and to submit provider data files used to populate its online provider directory to HSAG. At a minimum, the data elements requested for each provider included: provider name, Medicaid identification (ID), National Provider Identification (NPI) number, provider specialty, physical (practice) address, telephone number, provider taxonomy code, and whether the provider accepted new patients.

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

NAV Audit

HSAG collected network adequacy data from the MCOs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR Protocol 4.

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

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

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

Description of Data Obtained

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

1. PDV, to validate the MCOs' online provider directories to ensure members have appropriate access to provider information. HSAG utilized the MCOs' online provider directories to locate and extract provider data elements required to conduct the survey component of the PDV activity.
2. Provider access survey, to determine the accuracy of the managed care network information supplied to Healthy Louisiana members using the MCOs' provider data files and to ensure that Louisiana provider networks are following the established LDH standard for office-hour appointments. HSAG utilized the MCOs' provider data files used to populate their online provider directories to conduct the survey component of the provider access survey activity.
3. HSAG prepared a document request packet that was submitted to each MCO outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCO's IS and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the MCOs to conduct the NAV audits:
   - IS data from the ISCAT
   - Network adequacy logic for calculation of network adequacy indicators
   - Network adequacy data files
   - Network adequacy monitoring data
   - Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Data Were Aggregated and Analyzed

Provider Directory Validation

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

- Telephone number
- Address
- Office affiliation with the sampled provider
- Accuracy of provider specialty

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

HSAG used the following validation responses to assess each indicator:

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

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-14 were used to calculate the weight of each noncompliance survey outcome.

Table 5-14—Noncompliance Reasons and Weighting

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

Table 5-15—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-14. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

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

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75.

Provider Access Survey

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

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

Using the results of the survey, HSAG calculated a compliance score for each MCO. The criteria in Table 5-16 were used to calculate the weight of each noncompliance survey outcome.

Table 5-16—Noncompliance Reasons and Weighting

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

Table 5-17—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-16. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

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

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent.

NAV Audit

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

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

How Conclusions Were Drawn

Provider Directory Validation/Provider Access Survey

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Healthy Louisiana member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-18.

Table 5-18—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
PDV	✓		✓
Provider Access Survey	✓	✓	✓

NAV Audit

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 5-19.

Table 5-19—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100
Number of *Not Met* elements determined to have significant bias on the results.

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 5-20 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-20—Indicator-Level Validation Rating Categories

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

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCO provide a root cause analysis of the finding.
- Working with the MCE to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the

impact was unable to be quantified and therefore was determined to have the potential for significant bias.

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

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-21.

Table 5-21—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Provider: Enrollee Ratio	✓	✓	✓
Distance	✓	✓	✓
Access and Timeliness Standards	✓	✓	✓

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

Results

Table 6-1 presents ABH's 2022, 2023, and 2024 (review period) adult achievement scores.

Table 6-1—Adult Achievement Scores

Measure	2022	2023	2024
Rating of Health Plan	76.09%	76.09%	72.73%
Rating of All Health Care	75.68%	75.68%	65.79% ↓
Rating of Personal Doctor	84.56%	84.56%	80.62%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	NA	NA	NA
Getting Care Quickly	NA	NA	NA
How Well Doctors Communicate	91.80%	91.80%	NA
Customer Service	NA	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
↑ *Indicates the 2024 score is statistically significantly higher than the 2024 NCQA national average.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 NCQA national average.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Table 6-2 presents ABH's 2022, 2023, and 2024 (review period) general child achievement scores.

Table 6-2—General Child Achievement Scores

Measure	2022	2023	2024
Rating of Health Plan	86.45%	86.45%	83.26%
Rating of All Health Care	88.30%	88.30%	88.22%
Rating of Personal Doctor	92.27%	92.27%	91.88%
Rating of Specialist Seen Most Often	NA	NA	91.51%
Getting Needed Care	89.56%	89.56%	86.23%
Getting Care Quickly	86.59%	86.59%	91.30% ↑
How Well Doctors Communicate	95.88%	95.88%	94.91%
Customer Service	NA	NA	88.89%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
↑ *Indicates the 2024 score is statistically significantly higher than the 2024 NCQA national average.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 NCQA national average.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the adult population, ABH's scores were not statistically significantly higher in 2024 than 2023 nor statistically significantly higher than the 2024 NCQA national averages on any of the measures; therefore, no strengths were identified. **[Quality, Timeliness, and Access]**
- For the general child population, ABH's score for *Getting Care Quickly* was statistically significantly higher than the 2024 NCQA national average. **[Quality and Timeliness]**

For ABH, the following opportunities for improvement were identified:

- For the adult population, ABH's score for *Rating of All Health Care* was statistically significantly lower than the 2024 NCQA national average. **[Quality]**
- For the general child population, ABH's scores were not statistically significantly lower in 2024 than 2023 nor statistically significantly lower than the 2024 NCQA national averages on any of the measures; therefore, no opportunities for improvement were identified. **[Quality, Timeliness, and Access]**

For ABH, the following recommendation was identified:

- HSAG recommends that ABH conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need. **[Quality]**

Methodology

Objectives

The CAHPS activity assesses adult members' and parents'/caretakers' of child members experiences with an MCO and the quality of care that they/their children receive. The goal of the CAHPS surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) and mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents). In addition, some MCOs had an option for members to complete the survey in Spanish and Chinese. Adult members and parents/caretakers of child members completed the surveys from February through May 2024, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (39 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed members' experiences with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite measures.[6-1] The global ratings reflected patients' overall experiences with their personal doctor, specialist, MCO, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

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

[6-1] For this report, the 2024 Child Medicaid CAHPS results presented are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

For this report, HSAG did not include results for a CAHPS measure if the NCQA minimum reporting threshold of 100 respondents was not met. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to the 2024 NCQA CAHPS adult and general child Medicaid national averages.[6-2]

Description of Data Obtained

The CAHPS survey asks adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The MCOs contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experiences with their MCO during the last six months of the measurement period (i.e., July through December 2023).

The MCOs' CAHPS vendors administered the surveys from February to May 2024. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[6-3] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, did not meet the eligible population criteria, had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2024 achievement scores were compared to their corresponding 2023 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2024 achievement scores and the 2023 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2024 than 2023 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2024 than 2023 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was not denoted with a triangle.

Additionally, HSAG compared MCO scores to the NCQA national averages to determine if there were any statistically significant differences. An MCO that performed statistically significantly higher than the 2024 NCQA national average was denoted with a green upward arrow (↑).[6-4] Conversely, an MCO

6-2 National data were obtained from NCQA's 2024 Quality Compass.

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

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

that performed statistically significantly lower than the 2024 NCQA national average was denoted with a red downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2024 NCQA national average was not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2024 survey results to the 2024 NCQA national averages to determine if there were any statistically significant differences. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains. This assignment to the domains is depicted in Table 6-3.

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

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

7. Behavioral Health Member Satisfaction Survey

Results

Table 7-1 presents the 2023 and 2024 (review period) adult achievement scores for ABH and the Healthy Louisiana SWA.

Table 7-1—Adult Achievement Scores for ABH

Measure	2023	2024	Healthy Louisiana SWA
Rating of Health Plan	56.12%	50.00%	56.43%
How Well People Communicate	91.59%	90.41%	92.65%
Cultural Competency	90.91%+	93.33%+	82.85%+
Helped by Counseling or Treatment	64.03%	62.86%	69.38%
Treatment or Counseling Convenience	89.21%	85.00%	88.46%
Getting Needed Treatment	75.91%	79.86%	81.83%
Help Finding Counseling or Treatment	38.46%+	53.57%+	52.90%
Customer Service	57.89%+	65.00%+	71.32%
Helped by Crisis Response Services	63.64%+	77.78%+	75.17%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 Healthy Louisiana SWA.*

↓ *Indicates the 2024 score is statistically significantly lower than the 2024 Healthy Louisiana SWA.*

▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*

▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Table 7-2 presents the 2023 and 2024 (review period) child achievement scores for ABH and the Healthy Louisiana SWA.

Table 7-2—Child Achievement Scores for ABH

Measure	2023	2024	Healthy Louisiana SWA
Rating of Health Plan	52.63%+	61.40%+	65.18%
How Well People Communicate	93.12%+	91.95%+	90.74%
Cultural Competency	—	87.50%+	90.17%+
Helped by Counseling or Treatment	58.97%+	58.62%+	56.92%
Treatment or Counseling Convenience	97.44%+	82.76%+▼	86.12%
Getting Needed Treatment	79.49%+	74.55%+	77.13%
Help Finding Counseling or Treatment	37.50%+	28.57%+	46.93%+
Customer Service	50.00%+	42.86%+	59.54%+

Measure	2023	2024	Healthy Louisiana SWA
Getting Professional Help	87.18%+	84.21%+	85.72%
Help to Manage Condition	87.18%+	86.21%+	83.70%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
↑ *Indicates the 2024 score is statistically significantly higher than the 2024 Healthy Louisiana SWA.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 Healthy Louisiana SWA.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*
— *Indicates the MCO's score was not reported due to insufficient data.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the adult and child populations, ABH's scores were not statistically significantly higher than the 2024 Healthy Louisiana SWA nor statistically significantly higher in 2024 than 2023 on any of the measures; therefore, no strengths were identified. **[Quality, Timeliness, and Access]**

For ABH, the following opportunities for improvement were identified:

- For the adult population, ABH's scores were not statistically significantly lower than the 2024 Healthy Louisiana SWA nor statistically significantly lower in 2024 than 2023 on any of the measures; therefore, no opportunities for improvement were identified. **[Quality, Timeliness, and Access]**

- For the child population, ABH's 2024 score was statistically significantly lower than the 2023 score for *Treatment or Counseling Convenience*. **[Access]**

For ABH, the following recommendations were identified:

- HSAG recommends that ABH consider whether there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. **[Quality and Access]**
- HSAG recommends that ABH focus on increasing response rates to the behavioral health member satisfaction survey for the adult and child populations so there are greater than 100 respondents for each measure. ABH can achieve this by educating and engaging all employees to increase their knowledge of the behavioral health member satisfaction survey, using customer service techniques, further oversampling, and providing member and provider awareness during the survey period. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom behavioral health member satisfaction survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from June to August 2024.

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

For the global rating, HSAG calculated the percentage of respondents who chose a positive experience rating (i.e., a response of 9 or 10 on a scale of 0 to 10). For the composite measure, HSAG calculated the percentage of respondents who chose a positive response. The composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measure was a response of "Usually" or "Always." For the individual item measures, HSAG calculated the percentage of respondents who chose a positive response (i.e., "Usually/Always," "Yes," "A lot," or "Not a problem").

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2024 achievement scores were compared to their corresponding 2023 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2024 achievement scores and the 2023 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2024 than 2023 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2024 than 2023 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was not denoted with a triangle.

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

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care and services provided by the MCOs, HSAG assigned the measures evaluated in the behavioral health member satisfaction survey to one or more of these three domains. This assignment to domains is shown in Table 7-3.

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

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

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

8. Health Disparities Focus Study

While the 2023 (review period) Annual Health Disparities Focus Study included MCO-specific findings, the overall results and conclusions of this study are not MCO-specific. Therefore, please refer to the annual MCO aggregate technical report for high-level statewide findings from the 2023 Annual Health Disparities Focus Study.

Methodology

The Louisiana Medicaid Managed Care Quality Strategy outlines that one of LDH's objectives is to advance health equity and address social determinants of health. In an effort to measure and address health disparities, LDH and HSAG partnered to perform the 2023 Annual Health Disparities Focus Study. For the 2023 Annual Health Disparities Focus Study, HSAG identified statewide and MCO-specific disparities based on race, ethnicity, and geography using calendar year (CY) 2022 data.

Technical Methods of Data Collection

HSAG used the MCO-provided *Race Ethnicity and Rural Urban Stratification* Microsoft Excel (Excel) spreadsheets to identify disparities based on race, ethnicity, and geography for select HEDIS and non-HEDIS indicators. HSAG used the MY 2022 HEDIS IDSS data files and MY 2022 CAHPS data files to identify disparities for select HEDIS and CAHPS indicators based on race and ethnicity.

Description of Data Obtained

Table 8-1 displays all measure indicators, data sources, and the applicable stratifications that were assessed for health disparities. HSAG assigned each indicator to one of the following domains based on the type of care or health status being measured: Member Experience With Health Plan and Providers, Getting Care, Chronic Conditions, Children's Health, Women's Health, and Behavioral Health.

Table 8-1—Measure Indicators, Data Sources, and Stratifications Organized by Domains

Measure Indicator	Data Source	Stratification
Member Experience With Health Plan and Providers		
Rating of Health Plan—Adult (RHP–Adult) and *Child* (RHP–Child)	CAHPS Data	Race and Ethnicity
Rating of All Health Care—Adult (RHC–Adult) and *Child* (RHC–Child)		
Customer Service—Adult (CS–Adult) and *Child* (CS–Child)		
How Well Doctors Communicate—Adult (HWD–Adult) and *Child* (HWD–Child)		

Measure Indicator	Data Source	Stratification
Rating of Personal Doctor—Adult (RPD–Adult) and *Child* (RPD–Child)		
Rating of Specialist Seen Most Often—Adult (RSP–Adult) and *Child* (RSP–Child)		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit (MSC–Quit), *Discussing Cessation Medications* (MSC–Meds), and *Discussing Cessation Strategies* (MSC–Strategies)		
Getting Care		
Getting Needed Care—Adult (GNC–Adult) and *Child* (GNC–Child)	CAHPS Data	Race and Ethnicity
Getting Care Quickly—Adult (GCQ–Adult) and *Child* (GCQ–Child)		
Flu Vaccinations for Adults (FVA)		
Colorectal Cancer Screening (COL)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Chronic Conditions		
Controlling High Blood Pressure (CBP)^	HEDIS IDSS	Race and Ethnicity
HbA1c Control for Patients With Diabetes^—HbA1c Control (<8.0 Percent) (HBD–8) and *HbA1c Poor Control (>9.0 Percent)* (HBD–9)*	HEDIS IDSS	Race and Ethnicity
Human Immunodeficiency Virus (HIV) Viral Load Suppression (HVL)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Children's Health		
Child and Adolescent Well-Care Visits (WCV)	HEDIS IDSS	Race and Ethnicity
Childhood Immunization Status—Combination 3 (CIS–3)^	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Immunizations for Adolescents—Combination 2 (IMA–2)^		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)		
Low Birthweight Births (LBW)*		

Measure Indicator	Data Source	Stratification
Women's Health		
Cervical Cancer Screening (CCS)^	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Contraceptive Care—Postpartum Care—Long-Acting Reversible Contraception (LARC)—3 Days—Ages 21–44 (CCP–LARC3–2144) and *90 Days—Ages 21–44* (CCP–LARC90–2144)		
Contraceptive Care—Postpartum Care—Most or Moderately Effective Contraception (MMEC)—3 Days—Ages 21–44 (CCP–MMEC3–2144) and *90 Days—Ages 21–44* (CCP–MMEC90–2144)		
Prenatal and Postpartum Care^*—Timeliness of Prenatal Care* (PPC–Prenatal) and *Postpartum Care* (PPC–Postpartum)	HEDIS IDSS	Race and Ethnicity
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up (FUH–30)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM–30)		
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up (FUA–30)		

^ indicates a measure indictor that can be calculated using the hybrid methodology.
** indicates that a lower rate is better for this measure indicator.*

How Data Were Aggregated and Analyzed

Statewide Rate Calculations

HSAG calculated stratified rates for all HEDIS, non-HEDIS, and CAHPS measure indicators listed in Table 8-1. For the HEDIS and non-HEDIS measure indicators reported through IDSS files (HEDIS only) and the *Race Ethnicity and Rural Urban Stratification* Excel spreadsheets (HEDIS and non-HEDIS), HSAG extracted the stratified MCO-reported numerators, denominators, and rates provided in the reporting templates.

Additionally, HSAG used the survey responses provided in the CAHPS data files to calculate the stratified MCO-specific CAHPS rates. Each member was assigned a race and ethnicity based on their survey responses. To calculate a rate for a CAHPS measure indicator, HSAG converted each individual question by assigning the positive responses (i.e., "9/10," "Usually/Always," and "Yes" where applicable) to a "1" for each individual question, as described in *HEDIS MY 2022 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of "0." HSAG then calculated the percentage of respondents with a positive response (i.e., a "1"). For composite measures (i.e., CS, GNC, GCQ, and HWD), HSAG calculated the positive rating by taking the average percentage of positive ratings for each question within the composite. An MCO-specific

stratified rate was calculated by determining the percentage of respondents who gave a positive response for each race and ethnicity. For the Effectiveness of Care CAHPS measure indicators (i.e., MSC and FVA), HSAG identified the denominator and numerator in alignment with the *HEDIS MY 2022 Volume 2: Technical Specifications for Health Plans*.

HSAG then calculated a statewide aggregate for each HEDIS, non-HEDIS, and CAHPS measure indicator by summing the numerators and denominators reported by each MCO. For measure indicator rates that were reported using the hybrid methodology (please see Table 8-1 for measure indicators with a hybrid option), rates were based on a sample selected from the measure indicator's eligible population. For the *Immunizations for Adolescents—Combination 2* (IMA–2) indicator one MCO reported the hybrid measure using the administrative option (i.e., the rate is not based on a sample of cases). Given that one MCO's eligible population was larger than 411, HSAG transformed the administrative denominator and numerator to replicate a sample of 411 members in order to limit the overrepresentation of the MCO's members toward the SWA. To do this, HSAG first calculated a transformed weight by taking 411 divided by the eligible population of the total rate. HSAG then multiplied each stratified numerator and denominator by the transformed weight to calculate the transformed numerator and denominator. This method allowed for each stratification in the transformed rate to maintain the same proportion of the total population as the original rate, while also having the same performance (i.e., the transformed rate is equal to the original rate). Table 8-2 provides an example of how the transformed rates were calculated.

Table 8-2—Transformed Rate Calculation

Race Category	Eligible Population (A)	Numerator (B)	Rate (C)	Transformed Weight (D) 411/A	Transformed Denominator (E) A*D	Transformed Numerator (F) B*D	Transformed Rate (G) F/E
Total	5,000	2,500	50.00%	0.0822	411.0000	205.5000	50.00%
White	1,700	800	47.06%		139.7400	65.7600	47.06%
Black or African American	2,100	1,200	57.14%		172.6200	98.6400	57.14%
American Indian or Alaska Native	25	13	52.00%		2.0550	1.0686	52.00%
Asian	30	16	53.33%		2.4660	1.3152	53.33%
Native Hawaiian or Other Pacific Islander	10	6	60.00%		0.8220	0.4932	60.00%
Other	800	401	50.13%		65.7600	32.9622	50.13%
Unknown	335	170	50.75%		27.5370	13.9740	50.75%

Identifying Health Disparities

For the measure indicators listed in Table 8-1, HSAG identified statewide and MCO-specific disparities based on race, ethnicity, and geography, where applicable (see Table 8-1 for which stratifications apply to each measure indicator). Table 8-3 and Table 8-4 display the race and ethnicity categories that were included in each of the MCO-provided *Race Ethnicity and Rural Urban Stratification* Excel spreadsheets, HEDIS IDSS, and CAHPS data files, along with individual racial and ethnic groups that comprise each category. Given the variation in race and ethnicity categories across data files, HSAG included the individual racial and ethnic groups from each data source in the "Groups Included" columns in Table 8-3 and Table 8-4; however, the race and ethnicity categories listed were used in the analysis, where applicable.

Table 8-3—Race Categories

Race Category	Groups Included
White*	White
Black or African American	Black or African American, Black or African-American
American Indian or Alaska Native	American Indian or Alaska Native, American Indian and Alaska Native
Asian	Asian
Native Hawaiian or Other Pacific Islander	Native Hawaiian and Other Pacific Islander, Native Hawaiian or Other Pacific Islander
Other	Other, Some Other Race, Two or More Races
Unknown^	Unknown, Asked but No Answer

** indicates reference group for the identification of racial disparities.*
^ indicates for the CAHPS measure indicators, "Unknown" includes members who did not provide a response.

Table 8-4—Ethnicity Categories

Ethnicity Category	Groups Included
Hispanic/Latino	Hispanic/Latino, Hispanic or Latino
Non-Hispanic/Latino*	Non-Hispanic/Latino, Not Hispanic/Latino, Not Hispanic or Latino
Unknown^	Unknown Ethnicity, Declined Ethnicity, Asked but No Answer

** indicates reference group for the identification of ethnic disparities.*
^ indicates for the CAHPS measure indicators, "Unknown" includes members who did not provide a response.

Table 8-5 displays the geography categories and the parishes included in each.

Table 8-5—Geography Categories and Parishes

Geography	Parishes
Urban*	Acadia, Ascension, Bossier, Caddo, Calcasieu, East Baton Rouge, Jefferson, Lafayette, Lafourche, Livingston, Orleans, Ouachita, Plaquemines, Rapides, St. Bernard, St. Charles, St. James, St. John, St. Landry, St. Martin, St. Tammany, Terrebonne, Webster, West Baton Rouge
Rural	Allen, Assumption, Avoyelles, Beauregard, Bienville, Caldwell, Cameron, Catahoula, Claiborne, Concordia, DeSoto, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson Davis, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Pointe Coupee, Red River, Richland, Sabine, St. Helena, St. Mary, Tangipahoa, Tensas, Union, Vermilion, Vernon, Washington, West Carroll, West Feliciana, Winn
Unknown	Unknown

** indicates reference group for the identification of disparities.*

A disparity was identified if the relative difference between the demographic group (the group of interest) and the reference group was more than 10 percent. For rates for which a higher rate indicates better performance, the relative difference was calculated using the following equation:

$$Relative\ Difference = \frac{(Group\ of\ Interest\ Performance Rate - Reference\ Group\ Performance Rate)}{Reference Group\ Performance Rate}$$

For example, for identifying racial disparities, if the rate of eligible members receiving well-child visits for the White group was 65.0 percent and the rate for the Black or African American group was 45.0 percent, the rate for the Black or African American group (the group of interest) was below the rate for the White group (the reference group) by more than a 30 percent relative difference, indicating a disparity. This is shown in the equation below:

$$-30.8\% = \frac{(45.0\% - 65.0\%)}{65.0\%}$$

For measure indicators for which a lower rate indicates better performance,[8-1] the relative difference was calculated using the following equation:

$$Relative\ Difference = \frac{(Reference\ Group\ Performance Rate - Group\ of\ Interest\ Performance Rate)}{Reference Group\ Performance Rate}$$

For example, for identifying racial disparities, if the low birthweight rate for the Black or African American group was 13.0 percent and the rate for the White group was 9.0 percent, the rate for the Black or African American group (the group of interest) was above the rate for the White group (the reference group) by more than a 40 percent relative difference, indicating a disparity. This is shown in the equation below:

$$-44.4\% = \frac{(9.0\% - 13.0\%)}{9.0\%}$$

Disparities were categorized by the following color system:

1. indicates the rate for the group of interest was better than the reference group (i.e., the relative difference was more than 10 percent).
2. indicates the rate for the group of interest was worse than the reference group (i.e., the relative difference was less than −10 percent).
3. White cells indicate that a disparity was not identified.

How Conclusions Were Drawn

To draw conclusions about identified statewide and MCO-specific health disparities, HSAG first compared disparities identified for Louisiana Medicaid to national disparities and compared rates to the 2023 NCQA Quality Compass®,[8-2] national Medicaid HMO percentiles or the CMS Federal Fiscal Year (FFY) 2022 Child and Adult Health Care Quality Measures data,[8-3] where applicable. HSAG then assessed if specific measure indicators, domains, or demographic groups had disparities consistently identified.

[8-1] Please refer to those measure indicators in Table 8-1 marked with an asterisk (*) for measure indicators for which a lower rate indicates better performance.
[8-2] Quality Compass® is a registered trademark of the NCQA.
[8-3] Data. Medicaid.gov. 2022 Child and Adult Health Care Quality Measures. Available at: https://data.medicaid.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6. Accessed on: Dec 17, 2024.

9. Case Management Performance Evaluation

Introduction

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

Activities Conducted During SFY 2024

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

During SFY 2024, HSAG completed two CMPE reviews. Each review focused on specific populations of enrollees with special health care needs (SHCN):

- CY 2023 review (conducted from October through December 2023 [review period]): Enrollees with a classification of SHCN-Medical ("SHCN-MED"), SHCN-Behavioral Health ("SHCN-BH"), or "SHCN-BOTH" (composed of both MED and BH cases).
- CY 2024 review (conducted from March through April 2024 [review period]): Enrollees with a classification of SHCN-Department of Justice at-risk ("SHCN-DOJ-AR").

[9-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 17, 2024.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- The results of both reviews demonstrated that no findings resulted in concerns regarding an enrollee's health, safety, or welfare. **[Quality]**
- For the CY 2023 review, all three domains demonstrated overall performance greater than 80 percent. **[Quality]**
- The results of both reviews demonstrated that the health plan was successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans, and MCT development. **[Quality, Timeliness, and Access]**

For ABH, the following opportunities for improvement were identified:

- Both reviews determined that the health plan demonstrated opportunity for improvement with elements related to ongoing scheduled case management activities. **[Timeliness]**

For ABH, the following recommendations were identified:

- The health plan would benefit from strengthening documentation of an enrollee's refusal of in-person contact for completion of reassessments. HSAG noted that the health plan reported having a process to document refusal. The health plan may consider re-education of case managers on the expectations of the process. **[Quality and Timeliness]**
- The health plan should evaluate its unable to reach process to ensure alignment with LDH's expectations for outreach. **[Quality and Timeliness]**
- For the SHCN-DOJ-AR population, the health plan should continue to ensure documentation of all attempts to complete reassessments, plans of care (POCs) including POC updates, and enrollee contact. **[Quality and Timeliness]**
- For the SHCN-DOJ-AR population, the health plan should evaluate whether internal behavioral health subject matter experts can provide education or best practices to ensure case manager understanding of BH treatment plans and the importance of inclusion of the plan in the POC. **[Quality]**
- The health plan should evaluate its MCT process to ensure MCT meetings are conducted at regular intervals, or that an enrollee's refusal of MCT meetings is documented. The health plan should also review its MCT process to ensure that all MCT participants are invited to attend meetings and that declinations of attendance are documented. **[Timeliness]**
- The health plan should evaluate its oversight processes to ensure that case managers and supervisory staff have tools to effectively manage activities that occur regularly. Case management system flags, queues, or reports that remind staff members of upcoming contact requirements should be considered; leadership audits may need to focus on these time-sensitive elements. **[Quality and Timeliness]**

Methodology

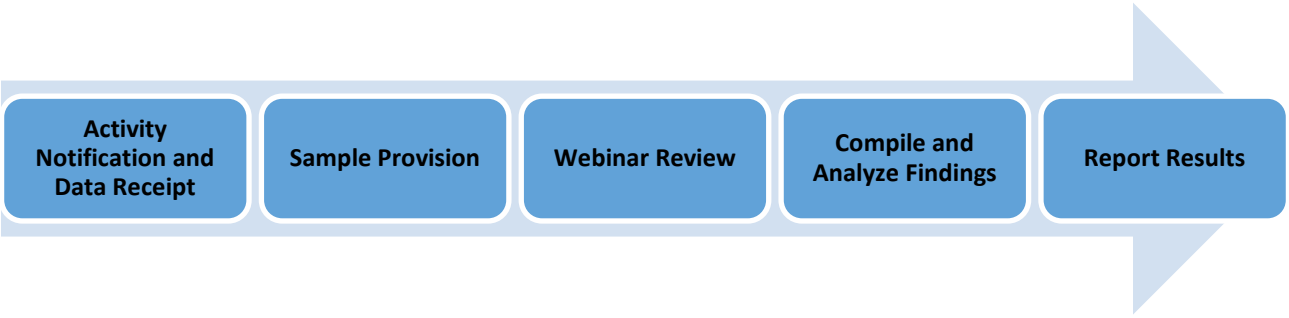
Objectives

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

HSAG's CMPE review tool comprehensively addressed the services and supports that are necessary to meet enrollees' needs. The tool included elements for review of case management documentation and enrollee care plans to ensure that they are consistent with a person-centered approach to care planning and service delivery and that outcomes are being achieved or progress is being made toward their achievement. The CMPE review tool included MCO contract requirements, evaluation criteria of those requirements, and reviewer determinations of performance.

Review Process

HSAG's case management review process included five activities:



Activity 1: Activity Notification and Data Receipt

To initiate the case management review, HSAG conducted an activity notification webinar for the MCOs. During the webinar, HSAG provided information about the activity and expectations for MCO participation, including provision of data. HSAG requested the *LA PQ039 Case Management* report from each MCO.

Table 9-1—Activity 1: Activity Notification and Data Receipt

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

Activity 2: Sample Provision

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

For the CY 2023 review:

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

For the CY 2024 review:

- Have a classification of "SHCN-DOJ-AR." HSAG identified these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Identified by the MCOs as "accepted" in the "enrollment offer result" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or after October 1, 2023. HSAG identified these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of at least three months. HSAG identified these enrollees by utilizing data from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.

If the criteria above did not allow for the sample size to be achieved, HSAG conducted a second stage approach to include enrollees meeting the following criteria:

- Have a classification of "SHCN-DOJ-AR." HSAG will identify these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Identified by the MCOs as "enrolled in case management" in the "assessment result" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or after October 1, 2023. HSAG will identify these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of less than 90 days as identified from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.
- Have a completed assessment and plan of care. HSAG will identify these enrollees by the "date of assessment" and "date plan of care completed" fields provided in the *LA PQ039 Case Management* report.

Enrollees who were identified by the MCOs for case management but not enrolled were excluded from the sample.

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

Based on the inclusion criteria, HSAG generated a random sample of enrollees for each MCO, which included a 10 percent oversample to account for exclusions or substitutions. HSAG provided each MCO with its sample 10 business days prior to the webinar review. The MCO was given five business days to provide HSAG with any requests for exclusions or substitutions. If the oversample was not large enough to obtain the necessary sample size, HSAG selected additional random samples to fulfill the sample size. The final sample of cases were confirmed with the MCO no later than three business days prior to the webinar review.

Table 9-2—Activity 2: Sample Provision

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

Activity 3: Webinar Review

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

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

The webinar review consisted of several key activities:

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

Table 9-3—Activity 3: Webinar Review

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

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

Scoring Methodology

HSAG used the CMPE review tool to record the results of the case reviews. HSAG used a two-point scoring methodology. Each requirement was scored as *Met* or *Not Met* according to the criteria identified below. HSAG used a designation of *NA* if the requirement was not applicable to a record; *NA* findings were not included in the two-point scoring methodology.

Met indicated full compliance defined as the following:

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

Not Met indicated noncompliance defined as either of the following:

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

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

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

Reporting of Abuse, Neglect, or Exploitation (ANE)

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

Activity 4: Compile and Analyze Findings

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

Domain and Element Performance

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

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

Analysis of findings included identification of opportunities for improvement.

Activity 5: Report Results

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

How Conclusions Were Drawn

Upon completion of the activity, HSAG provided results for each MCO in three performance domains: Assessment, Care Planning, and Enrollee Interaction and Coordination of Services. Each domain included scored elements, displayed in Table 9-4, which demonstrated each MCO's compliance with contractual requirements.

Table 9-4—Assignment of CMPE Measures to the Quality, Timeliness, and Access Domains

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

CMPE Measure	Quality	Timeliness	Access
A reassessment was completed in person quarterly with the enrollee.		✓	
A POC was developed within 30 calendar days of identification of risk stratification.		✓	
A POC was developed within 90 calendar days of identification of risk stratification. (2023 review only)		✓	
The MCO implemented a POC that was developed with the enrollee. (2024 review only)	✓		
The POC includes goals, choices, preferences, strengths, and cultural considerations identified in the assessment. (2024 review only)	✓		
The POC includes interventions to reduce all risks/barriers identified in the assessment. (2024 review only)	✓		
The POC incorporates the BH treatment plan, as applicable. (2024 review only)	✓		
The POC identifies the formal and informal supports responsible for assisting the enrollee. (2024 review only)	✓		
The MCO developed and implemented a person-centered care plan reflective of the most recent assessment and included all enrollee goals, needs, and risks as well as the formal and informal supports responsible for assisting the enrollee with the POC.	✓		
The POC was updated per the enrollee's tier schedule.		✓	
The POC was updated when the enrollee's circumstances or needs changed significantly, or at the request of the enrollee, their parent or legal guardian, or a member of the MCT.	✓		
The MCO developed an MCT, including the case manager, enrollee and/or authorized representative, and members based on the enrollee's specific care needs and goals.	✓		✓
The MCT was convened at regular intervals required for the enrollee's tier level.		✓	
The case manager made valid timely contact, or due diligence is documented in the enrollee's record.		✓	
For enrollees demonstrating needs requiring coordination of services, the case manager coordinated needed care/services, actively linking the enrollee to providers; medical services; and residential, social, community, and other support services.	✓		✓

10. Quality Rating System

Results

The 2024 (CY 2023 [review period]) QRS results for ABH are displayed in Table 10-1.

Table 10-1—2024 (CY 2023) QRS Results for ABH

Composites and Subcomposites	ABH
Overall Rating*	**3.5**
Consumer Satisfaction	**3.5**
Getting Care	4.5
Satisfaction with Plan Physicians	3.5
Satisfaction with Plan Services	2.5
Prevention and Equity	**2.5**
Children and Adolescent Well-Care	2.0
Women's Reproductive Health	2.5
Cancer Screening	2.0
Equity	5.0
Other Preventive Services	3.5
Treatment	**3.0**
Respiratory	3.5
Diabetes	3.5
Heart Disease	3.5
Behavioral Health—Care Coordination	1.5
Behavioral Health—Medication Adherence	3.5
Behavioral Health—Access, Monitoring, and Safety	4.0
Risk-Adjusted Utilization	3.0
Reduce Low Value Care	2.0

**This rating includes all measures in the 2024 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*

ABH received an Overall Rating of 3.5 points, with 3.5 points for the Consumer Satisfaction composite, 3.0 points for the Treatment composite, and 2.5 points for the Prevention and Equity composite.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the Consumer Satisfaction composite, ABH received 4.5 points for the Getting Care subcomposite and 3.5 points for the Satisfaction with Plan Physicians subcomposite. Both subcomposites are based on ABH member responses to CAHPS survey questions, demonstrating ABH members get the care they need and are satisfied with their providers. **[Quality and Timeliness]**
- For the Prevention and Equity composite, ABH received 5.0 points for the Equity subcomposite, demonstrating strength for ABH related to collecting race and ethnicity information from its members. Additionally, ABH received 3.5 points for the Other Preventive Services subcomposite, demonstrating strength for ABH related to providing chlamydia screenings in women and tobacco cessation counseling. **[Quality and Access]**
- For the Treatment composite, ABH received 4.0 points for the Behavioral Health—Access, Monitoring, and Safety subcomposite, demonstrating strength for ABH in providing care for adults and children using antipsychotics, adults and children with SUD, and children using ADHD medication. Additionally, ABH received 3.5 points for the Respiratory, Diabetes, Heart Disease, and Behavioral Health—Medication Adherence subcomposites, demonstrating strength for ABH related to respiratory, diabetic, and heart disease care as well as ensuring members with behavioral health issues stay on prescribed medications. **[Quality, Timeliness, and Access]**

For ABH, the following opportunities for improvement were identified:

- For the Consumer Satisfaction composite, ABH received 2.5 points for the Satisfaction with Plan Services subcomposite, demonstrating opportunities for improvement for ABH related to member satisfaction with ABH. **[Quality]**
- For the Prevention composite, ABH received 2.5 points for the Women's Reproductive Health subcomposite, demonstrating opportunities for improvement for ABH related to women receiving prenatal and postpartum care. Additionally, ABH received 2.0 points for the Children and Adolescent Well-Care and Cancer Screening subcomposites, demonstrating opportunities for ABH to ensure children receive vaccinations and weight assessments, and women receive cervical cancer screenings. **[Quality and Access]**
- For the Treatment composite, ABH received 2.0 points for the Reduce Low Value Care subcomposite, demonstrating opportunities for ABH to ensure members with low back pain do not receive unnecessary imaging tests. ABH received 1.5 points for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for ABH to ensure timely follow up after hospitalizations and ED visits for mental illness. **[Quality, Timeliness, and Access]**

For ABH, the following recommendation was identified:

- ABH should reference the recommendations made in Section 3—Validation of Performance Measures and Section 6—Consumer Surveys: CAHPS-A and CAHPS-C as the 2024 Health Plan Report Card reflects HEDIS and CAHPS results.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the five Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas.[10-1] The 2024 Health Plan Report Card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection

HSAG received MY 2023 CAHPS member-level data files and HEDIS IDSS data files from LDH and the six MCOs. The *HEDIS MY 2023 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2023 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Description of Data Obtained

HSAG received the final, auditor-locked HEDIS IDSS data files from each of the MCOs, as well as the CAHPS member-level data files and summary reports. HSAG also downloaded the 2023 (MY 2022) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[10-2]

How Data Were Aggregated and Analyzed

Using the HEDIS and CAHPS measure results for each MCO, HSAG calculated MCO ratings in alignment with NCQA's 2024 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[10-3]

- Overall
- Consumer Satisfaction
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan Services

[10-1] Due to HUM being a new MCO in 2023, there were no data available for this year's QRS activity. It will be included in a future Health Plan Report Card.

[10-2] 2023 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by August 5, 2024, and 2024 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were not available until September 27, 2024.

[10-3] National Committee for Quality Assurance. 2024 Health Plan Ratings Methodology. Available at: https://www.ncqa.org/wp-content/uploads/2024-HPR-Methodology_Updated-December-2023.pdf. Accessed on: Dec 17, 2024.

- Prevention and Equity
  - Children and Adolescent Well-Care
  - Women's Reproductive Health
  - Cancer Screening
  - Equity
  - Other Preventive Services
- Treatment
  - Respiratory
  - Diabetes
  - Heart Disease
  - Behavioral Health—Care Coordination
  - Behavioral Health—Medication Adherence
  - Behavioral Health—Access, Monitoring, and Safety
  - Risk-Adjusted Utilization
  - Reduce Low Value Care

For each measure included in the 2024 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2023 (MY 2022) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 10-2. For the *Plan All-Cause Readmissions* measure, HSAG followed NCQA's methodology for scoring risk-adjusted utilization measures.

Table 10-2—Measure Rate Scoring Descriptions

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

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 2024 Health Plan Ratings. For each composite and subcomposite, HSAG calculated scores using the following equation:

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

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

For the Overall Rating and each composite/subcomposite rating, HSAG aligned with NCQA's rounding rules and awarded scores as outlined in Table 10-3.

Table 10-3—Scoring Rounding Rules

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

How Conclusions Were Drawn

For the 2024 Health Plan Report Card, HSAG displayed star ratings based on the final scores for each rating. Stars were partially shaded if the MCO received a half rating (e.g., a score of 3.5 was displayed as 3.5 stars).

11. MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2024 to comprehensively assess ABH's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides ABH's strengths, opportunities for improvement, and recommendations in Table 11-1 through Table 11-3.

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

Overall MCO Strengths	
Quality, Timeliness, and Access	• ABH demonstrated strength in compliance by achieving compliance in all six elements from the CY 2023 CAPs. • ABH demonstrated strength by developing and carrying out methodologically sound designs and interventions for all five PIPs. • ABH had a strong provider network and demonstrated the importance of building strong partnerships with its providers to improve quality at a lower cost by aligning financial incentives. • ABH demonstrated strength in statewide provider-to-member ratios by provider type by meeting or exceeding LDH-established requirements. ABH demonstrated strength with behavioral health providers by meeting all LDH-established performance goals for three reported appointment access standards.
Quality and Access	• For the QRS Prevention and Equity composite, ABH received 5.0 points for the Equity subcomposite, demonstrating strength for ABH related to collecting race and ethnicity information from its members.

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

Overall MCO Opportunities for Improvement	
Quality and Access	• ABH demonstrated opportunities to improve the provider information that it maintains and provides.
Quality, Timeliness, and Access	• ABH had opportunity for improvement in several composites and subcomposites in the QRS including the Prevention and Equity composite, the Children and Adolescent Well-Care subcomposite, Cancer Screening subcomposite, the Reduce Low Value Care subcomposite, and the Behavioral Health–Care Coordination subcomposite.

Table 11-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
To facilitate significant outcomes improvement for all PIPs, HSAG recommends that ABH review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. ABH should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed through new or revised interventions to drive outcomes improvement.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities Goal 8: Minimize wasteful spending
HSAG recommends that ABH focus on increasing response rates to the behavioral health member satisfaction survey for its adult and child populations.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care
HSAG recommends that ABH evaluate performance measures with rates below the NCQA national 50th percentile.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 5: Improve chronic disease management and control Goal 6: Partner with communities to improve population health and address health disparities Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
HSAG recommends that LDH provide ABH with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which ABH will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance).	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care

Overall MCO Recommendations	
HSAG recommends that ABH conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
HSAG recommends that ABH conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 5: Improve chronic disease management and control Goal 6: Partner with communities to improve population health and address health disparities
HSAG recommends that ABH consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care.	Goal 1: Ensure access to care to meet enrollee needs

12. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2022–2023 recommendations. Table 12-1 through Table 12-9 contain a summary of the follow-up actions that ABH completed in response to the EQRO's SFY 2023 recommendations. Furthermore, HSAG assessed ABH's approach to addressing the recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

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

High indicates *all* of the following:

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

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

Medium indicates one or more of the following:

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

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

Low indicates one or more the following:

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

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

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

Recommendations
None identified.

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

1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
ABH should conduct a root cause analysis for the Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Mental Illness, and Follow-Up After Emergency Department Visit for Substance Use measures and implement appropriate interventions to improve performance, such as providing patient and provider education and enhancing communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
Response
Describe initiatives implemented based on recommendations: ABHLA offers continuous behavioral health and behavioral health/physical health integration training to all providers/staff free of charge and this training also has an on-demand aspect which allows any provider/staff who couldn't attend the live online training to access the material. Many of the training opportunities include continuing education hours towards physical health and behavioral health licenses and our training vendor also has a community board that is quite active with conversations etc. and sharing of knowledge and practices. ABHLA also includes follow-up metrics in our Value Base provider contracts and many of our BH providers performance have improved since July of 2023, when the new contracts went into effect. ABHLA continues to have CM outreach all hospital discharges, and for ED discharges on members already enrolled. For members not enrolled in CM upon discharge from an ED, we have areas that do outreach to help set up appointments as well as send reminders. In addition to the telephonic outreach, we have a text message that goes out weekly to all members who discharge for substance and or mental health as it aligns to the CPT codes for FUH/FUA/FUM. This text message includes links and phone numbers to areas in our network that can qualify for a follow-up appointment, and many are virtual. The value-based provider team holds a monthly PH/BH Integration Committee meeting. The team reviews their data and contracts during this call as well as their interventions including but not limited to:

1. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
• Notifications to providers in value-based arrangements of their assigned enrollees presenting to the ED for behavioral health concerns and notifications for substance abuse concerns. • Notifications to providers of their assigned enrollees being admitted to acute inpatient psych and enrollees admitted to acute inpatient detox. • Notifications included contact information for the member, care manager if assigned, facility, assigned UM staff member, and any discharge plans if known. • Behavioral Health Inpatient High Utilizer Reports were sent to value-based providers, including comprehensive information on enrollees who were hospitalized 3+ times over a 12-month period for behavioral health. • Provided education on behavioral health/substance abuse levels of care, best practices in follow-up care, follow-up measures (FUM, FUA, FUH), One Telemid, Provider-to-Provider Consultation Line, screening for behavioral health and substance abuse via the PHQ9, GAD, and SBIRT, Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD), Adherence to antipsychotic medications for individuals with schizophrenia (SAA), and screening for STIs in individuals with substance use disorders
Identify any noted performance improvement as a result of initiatives implemented (if applicable): During 2022-2023 ABHLA did have the highest FUA rates and before the measure was changed in late 2023 we were above the 50% quartile for that metric. Although FUM has only incrementally improved, we feel the changes made will need to be place longer than a year to see the full results. We feel the Value base provider incentives for both ED follow-ups, FUA/FUM, are showing progress for improvement as noted in the field above. For FUH, we will address in the last BH item in the list as it aligns to all discharges from mental health hospitals.
Identify any barriers to implementing initiatives: - Patient 'No show' for appointments including virtual appointments. - Low BH provider to member ratios and lack of appointments available within the specified time frame   o Provider complaints of low fees on Medicaid fee schedule - Health Literacy and understanding of need of services. - Mental Health and Substance Use Disorder stigma - Transportation Incorrect member contact information
Identify strategy for continued improvement or overcoming identified barriers: All improvements are aligned to the PIP for the appropriate metric and can be found in more detail in the end of year BH TOC PIP summary submitted in January of 2024 for the year of 2023.
HSAG Assessment

Recommendations
ABH should convene a focus group to conduct root cause analyses to determine barriers to child and adolescent members accessing preventive care. The focus group should include parent/guardian and provider participation as well as subject matter experts. The focus group should recommend evidenced based interventions that

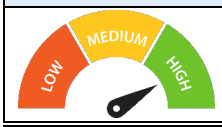
Recommendations
address barriers. ABH should consider holistic and novel interventions that aim to increase preventive care rates rather than reiterating previous interventions focused on specific topics or short-term campaigns.
Response
Describe initiatives implemented based on recommendations: ABHLA's Special Populations (Pediatrics) UM Nurse Consultant meets with caregivers to discuss barriers to child and adolescent preventative care. The UM Nurse Consultant provides individually tailored care plans that include evidence-based interventions and additional resources. ABHLA has considered holistic interventions such as non-clinical Social Determinants of Health (SDoH) through partnerships with the Healthy Families Produce Rx Program Project. This program provides eligible families with $40 per month to purchase fresh fruits and vegetables at select local farmers markets and grocery retailers with the goal of improving food security for families in rural Louisiana who are disproportionately impacted by poor nutrition and related health outcomes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): ABHLA has noted that through the Health Families Produce Rx Program Project, participant focus groups were completed in September 2023 with largely positive feedback and responses from participants. Some high-level insights from these focus groups include: • Participants strongly value the Healthy Families Produce Rx program and the impact it has on the health and wellness of the family • Many participants learned about the program through community or event spaces, trusted community members or through social media • Participants perceive their health plan, pediatrician, and related medical staff as trustworthy and would still be likely to apply if they promoted the program • Utilizing and redeeming the vouchers at the store was an overall positive experience, but in conversation, participants did identify a few key barriers to program utilization, many of which could be addressed through tweaks in program operations. • Participants underscored that the program increased the ability to include other family members in the shopping, cooking and meal preparation process Community Health Councils (CHCs) The UM Nurse Consultant continues to obtain feedback and individually tailor care plans and establish relationships and partnerships daily.
Identify any barriers to implementing initiatives: Resource capacity and member participation.
Identify strategy for continued improvement or overcoming identified barriers: The Health Families Produce Rx Program Project facilitated two community feedback sessions focused on gathering feedback, reactions, confirming understanding, and brainstorm ideas. Some of the discussion surrounded relationships and perceptions of information being shared through their pediatrician whom they deemed trustworthy. ABHLA is identifying member engagement and the best modalities for engagement (i.e., SMS, focus groups, live outreach). ABHLA is prioritizing the efficient use of existing resources as well as the development of a high-performing partnerships to create a continuum-wide network to increase access beyond the clinical setting. ABHLA is strategizing cross-departmentally on best practices and modalities using, but not limited to the follow resources: the Member Experience Diagnostic Survey Results, Community Resource Center Survey results, EAC feedback and will provide ease of access to online screeners including assessments, digital

Recommendations
coaching, health and wellness education, and information regarding local and national programs to promote member engagement.
HSAG Assessment

Recommendations
ABH should conduct a root cause analysis to determine barriers to women receiving cervical cancer screenings and implement appropriate interventions to improve performance. This analysis should consider whether unnecessary adolescent screenings are impacting adult women's willingness to receive screening as well as consider whether there are disparities within its population that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. In addition, ABH may compare strategies used to encourage members to receive screening for breast cancer as rates were better for that measure.
Response
Describe initiatives implemented based on recommendations: ABHLA outreach distributed member surveys to enrollees aged 25-50 years, for feedback regarding barriers they face when it comes to completing cervical cancer screenings. See results/barriers in the section below. ABHLA had and continues to do educational text campaigns to all female at birth members, we offer an incentive to get the screening done as well incent members to vaccinate since the HPV vaccine helps to reduce incidences of CCS. ABHLA has and will continue to reach out to those members who have not completed a CCS done and help them schedule an appointment. This telephonic outreach also allows our team to highlight the incentive for all preventative actions aligned to that member. ABHLA also sends a regular Gap in Care (GIC) report to its providers to highlight members who are needing specific things done with the request that providers outreach and get appointments scheduled. We also found common myths around who and when a CCS needs to be done among the members and will continue to text educational information as well as council in outreach calls.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): ABHLA performance year end 2022 to 2023 showed an improvement. We believe the measures we have in place will continue to improve the numbers as we are able to instill knowledge on screenings as well as incentives to have this done. The misunderstandings around CCS, age and legal gender, will continue to be a focus.
Identify any barriers to implementing initiatives: The survey highlighted the following barriers; accessibility to providers who share the same race, gender, and cultural backgrounds, scheduling conflicts, lack of education regarding age, no recommendation from health care professional, limited and inflexible appointment times, transportation issues, lack of access, fear of screening results, lack of education regarding screening options. ABHLA members can access providers who accept Medicaid so meeting some of the barriers in the survey due to providers available in that area of the state will and can only be overcome with time. Perhaps improving the fees will incent more providers to accept Medicaid.
Identify strategy for continued improvement or overcoming identified barriers: All strategies and improvements are aligned and noted in great detail in the CCS PIP end of year report.

Recommendations
If members under the recommended age for CCS are screened it is the providers call, but if the claim is not substantiated with 'cause' the claim will be denied. Education for that provider will also be done to highlight the guidelines but there are instances when screening below the recommended age may be warranted and only the provider interfacing with the member would know. We can only require documentation to support the action or deny the claim.
HSAG Assessment

Recommendations
Require the MCOs to conduct a root cause analysis for measures associated with members with schizophrenia and implement appropriate interventions to improve performance.
Response
Describe initiatives implemented based on recommendations: - A Behavioral Health Resources SMS mPulse campaign was sent to all members. - An Anti-Depression Medication Management (AMM) & Schizophrenia Medication Adherence SAA IVR mPulse campaign was sent to adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medications as well as adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressants. - ABHLA offers continuous behavioral health and behavioral health/physical health integration training to all providers/staff free of charge and this training also has an on-demand aspect which allows any provider/staff who couldn't attend the live online training to access the material. Many of the training opportunities include continuing education hours towards physical health and behavioral health licenses and our training vendor also has a community board that is quite active with conversations etc. and sharing of knowledge and practices. - The value-based provider team holds a monthly PH/BH Integration Committee meeting. The team reviews their data and contracts during this call as well as their interventions including but not limited to: o Notifications to providers in value-based arrangements of their assigned enrollees presenting to the ED for behavioral health concerns and notifications for substance abuse concerns o Notifications to providers of their assigned enrollees being admitted to acute inpatient psych and enrollees admitted to acute inpatient detox o Notifications included contact information for the member, care manager if assigned, facility, assigned UM staff member, and any discharge plans if known o Behavioral Health Inpatient High Utilizer Reports were sent to value-based providers, including comprehensive information on enrollees who were hospitalized 3+ times over a 12 month period for behavioral health o Provided education on behavioral health/substance abuse levels of care, best practices in follow-up care, follow-up measures (FUM, FUA, FUH), One Telemed, Provider-to-Provider Consultation Line, screening for behavioral health and substance abuse via the PHQ9, GAD, and SBIRT, Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD), Adherence to antipsychotic medications for individuals with schizophrenia (SAA), and screening for STIs in individuals with substance use disorders

Recommendations
Identify any noted performance improvement as a result of initiatives implemented (if applicable): ABHLA's HEDIS SAA measure (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has steadily increased YOY (2021: 54.64%; 2022: 55.81%; 2023: 58.31%). This measure has a 2024 forecasted rate of 60.81%, which is a 2.5% increase from 2023MY and a 6.17% rate increase from 2021MY.
Identify any barriers to implementing initiatives: - Concerns with medication adherence for patients with Schizophrenia - Low BH provider to member ratios and lack of appointments available within the specified time frame   o Provider complaints of low fees on Medicaid fee schedule - Health Literacy and understanding of need of services - Mental Health and Substance Use Disorder stigma - Transportation - Incorrect member contact information
Identify strategy for continued improvement or overcoming identified barriers: - Medication adherence is part of the Readmission Avoidance Program (RAP) score that Care Management uses to determine level of services needed for members. CM will use the RAP score to identify members most in need. - ABHLA can work with Pharmacy data to identify members who are late refilling their antipsychotics, and then work with providers to notify them of their patients that are non-compliant with their medications. - ABHLA will keep an internally shared, updated Behavioral Health specific provider referral file that denotes if the BH providers offer MAT Services, Telehealth, and/or in-person services. This file will be available for ABHLA staff as a quick reference guide to refer members who are in crisis or in need of behavioral health appointments and will allow our staff to quickly and appropriately refer members to services (by geographical location, service type, provider gender, language offered, etc.). - ABHLA will sponsor continuing education for providers to combat challenges for members with mental health needs. - ABHLA will continue to work cross-departmentally to maintain value-based contracts and attract providers to join or continue to be a part of our provider network. - ABHLA will continue to use SDoH assessments and communicate with our members that have food and housing insecurities to support their basic needs, offer appropriate resources, mitigate visits to the ED, and to be able to refer to appropriate care. - An additional resource that ABHLA offers is a social isolation and loneliness app called Pyx. Members continue to onboard month over month, and Pyx's evidence-based interventions decreases depression, anxiety, loneliness, emergency room visits/readmissions, and identifies SDoH needs to close social care gaps.
HSAG Assessment

Recommendations
Require the MCOs to conduct a root cause analysis to determine why members are not receiving appropriate treatment of respiratory conditions and implement appropriate interventions to improve performance.

Recommendations
Response
Describe initiatives implemented based on recommendations: Asthma is a focus area of our case management and outreach programs. ABHLA has an active incentive to provide assessments and hypoallergenic supplies (pillow covers, sheets) to members.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): ABHLA's asthma related HEDIS outcomes have increased in Star performance over the past 3 years. 2021 – 3 star, 2022 – 4 star, 2023 – 5 star
Identify any barriers to implementing initiatives: Primary barriers come from connecting with members directly through CM and outreach.
Identify strategy for continued improvement or overcoming identified barriers: Given ABHLA's 2023 5 star performance, major changes are not being made to the program.
HSAG Assessment


Recommendations
Require the MCOs to focus efforts on decreasing unnecessary imaging and screenings. The MCOs should conduct a root cause analysis and implement appropriate interventions to decrease unnecessary imaging for low back pain and unnecessary screenings for cervical cancer among adolescent females.
Response
Describe initiatives implemented based on recommendations: ABHLA currently uses a vendor, Evicore for review of requests for imaging. EviCore does focus on reducing unnecessary imaging of low back pain. The Choosing Wisely campaign was created as an initiative of the American Board of Internal Medicine (ABIM) that provides practical evidence-based tools to support clinical decision-making. ABHLA's current process for cervical cancer screenings does not include adolescent females unless they are sexually active. Imaging of the lower back includes plain x-rays in addition to advanced imaging studies – CT and MRI. EviCore does not prior authorize plain x-rays of the lower back. The EviCore clinical criteria for advanced imaging studies of the back are aligned with the Choosing Wisely recommendation.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): None
Identify any barriers to implementing initiatives: None
Identify strategy for continued improvement or overcoming identified barriers: Evicore's recommendation was to not order imaging for low back pain with the first six weeks of symptoms unless "red flags" are present. ABHLA will continue to communicate with providers best practices for cervical cancer screenings for adolescent females and imaging for low back pain in accordance with Evicore's recommendation.
HSAG Assessment


Recommendations
Require the MCOs to focus efforts on increasing timely follow-up care, following discharge, for members who access the hospital and ED for mental illness or substance abuse. The MCOs should conduct a root cause analysis and implement appropriate interventions to improve performance.
Response
Describe initiatives implemented based on recommendations: ABHLA offers continuous training to all providers/staff free of charge and this training also has an on-demand aspect which allows any provider/staff who couldn't attend the live online training to access the material. Many of the training opportunities include continuing education hours towards physical health and behavioral health licenses and our training vendor also has a community board that is quite active with conversations etc. and sharing of knowledge and practices. ABHLA has a monthly meeting that focuses on our BH/PH connection within our Value Base provider contracts around performance. These meetings have been very beneficial to identify providers doing this well and allowing us to offer more training or even peer review with a high performer to help change steps for improvement. ABHLA continues to have CM telephonically outreach all hospital discharges, and for ED discharges on members already enrolled. For members not enrolled in CM upon discharge from an ED, we have areas that do outreach to help set up appointments as well as send reminders.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): During 2022-2023 ABHLA did have the highest FUA rates and before the measure was changed in late 2023 we were above the 50% quartile for that metric. Although FUM has only incrementally improved, we feel the changes made will need to be place longer than a year to see the full results. We feel the Value base provider incentives for both ED follow-ups, FUA/FUM, are showing progress for improvement as noted in the field above.
Identify any barriers to implementing initiatives: - Patient 'No show' for appointments including virtual appointments - Low provider to member ratios and lack of appointments available within the specified time frame - Complaints of low fee schedule to see Medicaid patients - Health Literacy and understanding of need of services - Mental Health and Substance Use Disorder stigma - Transportation - Incorrect member contact information
Identify strategy for continued improvement or overcoming identified barriers: In 2022, the ABHLA team began an activity to imbed a CM into a BH hospital to help with discharge planning as well local resources. This partnership was focused on those members who were most likely to be readmitted within 30 days due to past admits, lack or provider visits and/or pharmacy claims. The effort was to see if building a relationship via face to face could improve odds in enrolling these members into CM for oversight. It did increase the odds of enrollment from the prior year as well as giving us insight into the facility/practices/resources etc. that may be impacting follow-up support. This program's success allowed us to add additional headcount in 2023 and ABHLA is working to imbed resources into more MH hospitals and we currently have upwards of 4 that CHW's make regular rounds to when a member is admitted. We are working with other MH hospitals to offer the same support, but this is completely dependent on the facility for approval. It is important to note ABHLA removed all exclusions for their interventions aligned to the BH PIP which allows us to monitor all incidents where improvement can happen and therefore all initiatives for the PIP also

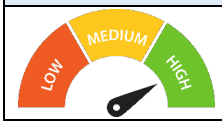
Recommendations
align to the whole MH and SUD discharge population to make sure the process is improving in delivery and education. ABHLA's Treatment Record Review (TRR) team will continue to hold compliance trainings for BH Providers that include discharge planning for different agency types, and ABHLA will continue to sponsor continuing education for providers to combat stigma, health literacy, and how to connect with members to understand their personal needs. ABHLA will continue to use SDoH assessments and communicate with our members that have food and housing insecurities to support their basic needs, offer appropriate resources, mitigate visits to the ED, and to be able to refer to appropriate care. An additional resource that ABHLA offers is a social isolation and loneliness app called Pyx. Members continue to onboard month over month, and Pyx's evidence-based interventions decreases depression, anxiety, loneliness, emergency room visits/readmissions, and identifies SDoH needs to close social care gaps.
HSAG Assessment


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

Recommendations
None identified.

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

2. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
To improve access to care, ABH should adopt a programmatic approach to identify barriers to access across all aspects of Medicaid operations. A plan wide taskforce should include provider network staff members, subject matter experts for the access-related HEDIS measures that performed poorly, utilization management staff members, and other members as determined by ABH. The taskforce should include key community stakeholders to identify barriers/facilitators to members accessing preventive and follow-up care. ABH should consider multi-tiered approaches such as: • Reviewing provider office procedures for ensuring appointment availability standards. • Conducting "secret shopper" provider office surveys. • Evaluating member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. • Conduct drill-down analyses of access-related measures to determine disparities by race, ethnicity, age group, geographic location, etc.

2. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
Response
Describe initiatives implemented based on recommendations: ABHLA implemented a committee consisting of network providers, provider network staff members, subject matter experts for HEDIS measures, utilization management, and other key staff members. This committee reviews network adequacy and appointment availability standards. ABHLA has also implemented a member and provider satisfaction workgroup also consisting of key staff members. This workgroup reviews member and provider satisfaction survey results, barriers to accessing care, conducts drill down analysis by race, ethnicity, language, and geographic locations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): None
Identify any barriers to implementing initiatives: None
Identify strategy for continued improvement or overcoming identified barriers: ABHLA will continue to facilitate the committee and work group.
HSAG Assessment

Recommendations
To increase accuracy of online provider directories: • Provide each MCO with the case-level PDV data files and a defined timeline by which each plan will address provider data deficiencies. • Require the MCOs to conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent.
Response
Describe initiatives implemented based on recommendations: ABHLA has participated in a project facilitated by LDH to increase the accuracy of the online provider directory. The network adequacy project included outreach to all providers to confirm their data, and required attestations for providers who did not have claims within the past 6 months.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): None
Identify any barriers to implementing initiatives: None
Identify strategy for continued improvement or overcoming identified barriers: ABHLA will continue to coordinate with LDH to increase the accuracy of the online provider directory.
HSAG Assessment


Recommendations

To improve compliance with GeoAccess standards:

- Require the MCOs to contract with additional providers, if available.
- Encourage strategies for expanding the provider network such as enhanced reimbursement or expanding licensing to add additional ASAM LOCs.
- Require the MCOs to conduct an in-depth review of provider types for which GeoAccess standards were not met to determine cause for failure and evaluate the extent to which the MCO has requested exemptions from LDH for provider types for which providers may not be available or willing to contract.
- Require the MCOs to evaluate whether offering additional telehealth services could increase compliance with GeoAccess standards.

Response

Describe initiatives implemented based on recommendations:

Aetna Better Health Louisiana (ABHLA) performs ongoing network monitoring and continuously recruits provider types with geographic coverage deficiencies. Through our monthly Network Management Strategy meetings, ABHLA develops enhanced reimbursement rates and value-based programs as appropriate to close coverage gaps.

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

As demonstrated below, ABHLA greatly improved our ASAM coverage in 2024 through a series of recruitment initiatives and provider data remediation.

Network Adequacy - Behavioral Health				
	Urban		Rural	
Provider Type/Level of Care	% of Members with Access 2024Q2	% of Members with Access 2023Q4	% of Members with Access 2024Q2	% of Members with Access 2023Q4
ASAM 1 SU RTF - Adult	94.10%	54.70%	91.40%	41.00%
ASAM 2.1 SU RTF - Adult	89.00%	71.10%	72.20%	55.00%
ASAM 2 SU WM RTF - Adult	75.40%	78.50%	24.60%	85.60%
ASAM 3.1 SU RTF - Adult	74.70%	57.50%	37.30%	7.90%
ASAM 3.2 SU WM RTF - Adult	62.50%	7.20%	51.30%	34.00%
ASAM 3.3 SU RTF - Adult	70.80%	58.40%	33.50%	12.90%
ASAM 3.5 SU RTF - Adult	93.20%	14.20%	48.60%	8.80%
ASAM 3.7 SU RTF - Adult	84.10%	3.50%	71.40%	17.40%
ASAM 3.7 SU WM RTF - Adult	83.40%	83.10%	64.20%	39.50%
ASAM 3.1 SU RTF - Pediatric	90.90%	72.40%	90.90%	72.40%
ASAM 3.2 SU WM RTF - Pediatric	67.40%	10.00%	67.40%	10.00%
ASAM 3.5 SU RTF - Pediatric	92.70%	16.90%	92.60%	16.90%

Recommendations
Identify any barriers to implementing initiatives: Some behavioral health specialties have a true shortage in Louisiana. The Office of Behavioral Health (OBH) is working in conjunction with the Managed Care Organizations (MCOs) and willing providers to expand service coverage and licensure authority.
Identify strategy for continued improvement or overcoming identified barriers: ABHLA Network Management and leadership teams will continue to work with OBH and other MCOs to review reimbursement methodology and licensure scope.
HSAG Assessment


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

Recommendations
None identified.

Table 12-6—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey

3. Prior Year Recommendations from the EQR Technical Report for the Behavioral Health Member Satisfaction Survey:
Require the MCOs to implement strategies to increase response rates to the behavioral health member satisfaction survey.
Response
Describe initiatives implemented based on recommendations: ABHLA launched an mPulse text campaign notifying members of upcoming survey.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): ABHLA will not have the response rate data to compare to the 2023 response rates until Q1 2025.
Identify any barriers to implementing initiatives: The mPulse campaign launched successfully.
Identify strategy for continued improvement or overcoming identified barriers: ABHLA will discuss this survey and health literacy at Enrollee Advisory Committee (EAC) meetings.
HSAG Assessment


Table 12-7—Follow-Up on Prior Year's Recommendations for Health Disparities Focus Study

Recommendations
None identified.

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

Recommendations
None identified.

Table 12-9—Follow-Up on Prior Year's Recommendations for Quality Rating System

Recommendations
None identified.

Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from ABH's Health Equity Plan (HEP) submission from July 2024.

Health Equity Plan

HSAG reviewed ABH's HEP[A-1] submitted July 2024. HSAG organized the discussions in this report as each MCO presented the topics in its own HEP. Therefore, comparison across the MCOs for the "Development and Implementation of Focus Areas," "Cultural Responsiveness and Implicit Bias Training," and "Stratify MCO Results on Attachment H Measures" sections of the HEP is not possible.

[A-1] Please note that the narrative within the "MCE Response" section was provided by the MCE and has not been altered by HSAG except for formatting.

Development and Implementation of Focus Areas

1. Health Equity Action Plan by Focus Area
Focus Area: Access to Care and Service Utilization
Goal (1): Improve equitable access to primary care providers among underserved populations within ABH LA member communities.
Participants: Health Equity Administrator, Quality Management, Network Management
Strategy: Implement a comprehensive, data-informed approach to identify and address barriers ABH LA members face in finding and visiting a primary care provider to improve access to primary care for ABH LA Hispanic/LatinX member through a targeted intervention
Activity: Conduct annual assessment of ABH LA members and community to identify barriers members face in accessing primary care services. Ensure that outward facing communications tests potential publications with Enrollees for understanding and conveyance of the intended message, as well as cultural appropriateness with Spanish speaking populations
Measurable Objective: • Achieve a 2% increase in the percentage of ABH LA LatinX members with at least one visit to Primary Care within 3 years • Hold quarterly JOC meetings with primary care groups in priority communities annually
Milestones to be Completed by December 2024: Create primary care visit report that stratifies members by race, ethnicity, language, geographic location, and assigned provider
ABHLA's goal is to improve equitable access to primary care providers among underserved populations within our member communities. We believe that everyone should have equal access to quality healthcare, regardless of their socioeconomic status or background. Through targeted outreach efforts and innovative programs, we aim to ensure that all individuals have the opportunity to receive the care they need to live healthy and fulfilling lives. Annually, ABHLA assesses enrollee satisfaction with services and quality of care provided, by initiating our CAHPS, or Consumer Assessment of Healthcare Providers and Systems survey (Adult & Child). The survey results help us identify areas for improvement and ensure that our members are receiving the best possible care. Utilizing the results, we focus our efforts on race, ethnicity, language, and cultural competency to address disparities within our member populations. We also use the feedback to develop cross-functional workgroups to make any necessary changes to our services in order to better meet the needs of our members. ABHLA also offers language translation services, as well as, translated print materials to our members to ensure that language barriers do not impede access to care. Our commitment to quality improvement and addressing disparities extends to all facets of our operations, demonstrating our dedication to providing the highest level of care to all of our members. As a result of our workgroups, we determined that there are two measurable objectives or goals we will continue to focus on: 2% YoY increase in primary care provider visits with LatinX members within 3 years and ABHLA leading quarterly JOC meetings with our primary care groups in priority communities annually to ensure alignment and coordination in our efforts to improve healthcare outcomes for all of our members. As it relates to increasing PCP visits within LatinX members, as of March 2024, our health equity data shows a baseline rate of 52.5% regarding the metric "% Members with at least one visit to Primary Care" While we are still receiving monthly updates on our data, we aim to increase this rate by 2% over the next 3 years. Our goal is to reach a rate of 54.5% by December 2026. Although our health equity dashboard has a slight delay in displaying current values, we are working closely with our quality department to attain the most current data as soon as possible. ABHLA takes pride in working with provider groups to collaborate and come up with innovative solutions to improve health outcomes for all members. Quarterly, we host JOC, or Joint Operating Committee meetings with our primary care provider groups. These meetings allow us to discuss current data trends, address any challenges, and brainstorm new strategies to

achieve our goals. By fostering this open communication and collaboration, we believe we can make significant strides in improving health equity and outcomes for our members. So far, January through June 2024, we have hosted 21 meetings with various provider groups spanning across different regions within the state. Our goal is to continue scheduling and hosting these meetings throughout the rest of the year to further drive progress and collaboration. Providing our provider partners with useful tools to enhance patient care and improve outcomes is also a priority for us. At this time, we have several existing reports that can be utilized to share open gaps in care for our members. One specific report we identified as being a great resource for our provider groups is the "ED_Diversion_PCP" report. While analyzing the data in this report, we have identified the need to update the criteria to be more inclusive of stratified information, which includes member race, ethnicity and language. An Informatics IT ticket was placed with our national data team to add those key elements to future reports. The process takes approximately two weeks to complete. It is our hope that this request will be fulfilled by June 30th. This report already has a great deal of information useful to our provider groups, however, we are updating the report fields to cover all necessary elements. Once the report is in production, our goal is to have our provider-facing teams filter the data by individual provider groups and send these reports directly to our contacts at these individual facilities weekly. Our Health Equity and Quality teams will continue to monitor the data and ensure that any disparities are addressed promptly. We also have a "Gaps in Care" report our provider facing teams utilize to discuss open care gaps based on HEDIS measures. Our goal is to have further discussions with the national informatics teams to inquire about optimizing this report's capabilities to include stratified information as well. This process will take time and manpower. By December 2024, we will have an update on if this report could be utilized with modifications, or if an alternative version can be created. By streamlining our reporting capabilities, we aim to improve communication and collaboration with our provider groups, ultimately leading to better member outcomes and overall access to care.
Focus Area: Chronic Disease Management
Goal (1): Reduce health disparities in chronic disease outcomes, specifically targeting diabetes and hypertension, among underserved and vulnerable populations within our member communities
Participants: Health Equity Administrator, Quality Management – Population Health Program Manager, Care Management Manager
Strategy: Implement a targeted, culturally sensitive, and accessible intervention to address the unique needs of populations disproportionately affected by chronic diseases, particularly focusing on diabetes and hypertension management among Black, White, and rural member populations
Activity: • Targeted in-home support for diabetes management: provide tailored in-home care and education programs in languages and formats accessible to diverse populations, with a focus on areas with high rates of diabetes • Culturally Appropriate Nutritional Intervention Program: offer home-delivered, culturally appropriate, and dietary-specific meals, ensuring accessibility for low income, rural, and ethnically diverse members • Provider Action Reports with Health Equity Focus: Distribute action reports to providers with data stratified by race, ethnicity, language, and geography to highlight disparities in blood pressure and diabetes management.
Measurable Objective: • Generate and distribute Provider Reports by December 2024 • 100% of all delivered meals are assessed for cultural appropriateness • Achieve 2% improvement in diabetes management among ABH LA members for priority populations
Milestones to be Completed by December 2024: Launch the targeted in-home support for diabetes and culturally appropriate nutritional intervention program by December 2024

Chronic disease management is another area where we focus on addressing disparities and promoting health equity. Our overarching goal is to reduce health disparities in chronic disease outcomes targeting diabetes and hypertension among underserved and vulnerable populations. Members who have these conditions are identified via member claims data & HEDIS care gaps reports. Our RN Health Coach reviews these reports, identifies members who are not currently in care management and begins her outreach to opt members into healthy coaching. Our goal is to educate and empower our members to make informed decisions about their health, leading to better overall outcomes and a higher quality of life. Through regular communication and support with our RN Health Coach, we strive to build strong relationships with our members and help them navigate the complexities of managing chronic conditions. ABHLA provides a space for inclusivity, ensuring that all educational resources and materials are in an acceptable and accessible format to support our diverse membership. If a member should require translation of information, we rely on our translation services to ensure that language barriers do not impede access to care. As it relates to targeted in home support, ABHLA participates in HHV or Healthy Home Visit, a member-centric program that offers a different perspective to the member's care. It is often thought of as the traditional house call. A clinical licensed NP or Physician will visit the member in the comfort of their home. This is not to be mistaken as home health services, this approach is more of an ancillary service to ensure that we have a complete and accurate picture of our member's health status. This program is not intended to replace the relationship with the member's PCP. Instead, it helps ABHLA work with their PCP to manage care and direct them to health programs and services needed. Participation in this program is voluntary and does not affect the member's coverage. The vendor we utilize for this program is Signify Health. An introductory letter is mailed to the member's home, introducing the program followed by a phone call in an attempt to schedule a visit. Once scheduled, the clinician will assess the "whole person", not only evaluating medical needs like medication and care gaps but also non-medical factors such as safety and nutrition, gathering and sharing information on members' home environments and social determinants of health. As of May 2024, we have completed 3,700 assessments. Our goal is to continue offering this program. We are dedicated to promoting health and wellness for all members, especially those with diabetes and hypertension.

In addition to education and support, ABHLA has initiated a culturally appropriate nutritional intervention program with the company, GA Foods. Our strategy in partnering with this organization is to reduce food and nutrition insecurities of members with chronic conditions through targeted efforts. We introduce members to the knowledge and skills needed to make healthy food choices. The GA Foods vendor cooks and delivers nutritious, medically appropriate meals to enrollees. (non-specialty tms, breakfast, vegetarian, puree, renal, kosher, shelf stable, medically tailored meals) Eligible member criteria are adult and non-compliant with CBP and HBD HEDIS measures. Enrollee files, or HEDIS data and claims data, are used to identify eligible members. Providers then place an order for the member to receive these services. Members are able to participate in this program every quarter (if they are still not compliant with CBP and HBD). They are provided with 2 meals per day for 14 days, for a total of 28 meals quarterly. When approved for the service, members are notified through outreach within 24-72 hours of receiving authorization. GA Foods provides a welcome call to discuss the program's value and services offered. GA Foods also completes/confirms referrals and the delivery of meals. Members are also notified about each status update: "referral received, member reached, accepted meals & delivery, refused meals & unable to reach" Although our goal is to help with providing nutritionally appropriate meals, there are limitations or barriers, such as the inability to reach members to set up their meal service. Inactive or inaccurate phone numbers would be the top challenge. In this instance, we continue to work with our members, GA Foods, and our provider partner to attain accurate contact information to ensure

members are given the opportunity to receive the meals they deserve. We are also in the process of operationalizing efforts with our RN Health Coach to be able to outreach the members who are currently receiving food boxes from this program. At this time, this process is not in production, however by December 2024, we should be outreaching these members for their feedback on this program. Our team is dedicated to making sure that all obstacles are overcome so that every member can benefit from our meal service. Providing our provider partners with useful tools to enhance patient care and improve outcomes is also a priority for us. As mentioned previously, the specific report that we have identified being active, most current and optimizing is our "ED_Diversion_PCP" report. While analyzing the data in this report, we have identified the need to update the criteria to be more inclusive of stratified information, which includes member race, ethnicity, and language. Several diagnoses, including DM and HTN are visible on this report to highlight disparities in blood pressure and diabetes management. An Informatics IT ticket was placed with our national data team to add those key elements to future reports. The process takes approximately two weeks to complete. It is our hope that this request will be fulfilled by June 30th. We are updating the report fields to cover all necessary elements. Once the report is in production, our goal is to have our provider-facing teams filter the data by individual provider groups and send these reports directly to our contacts at these individual facilities. We also have a "Gaps in Care" report our provider facing teams utilize to discuss open care gaps based on HEDIS measures. Our goal is to have further discussions with the national informatics teams to inquire about optimizing this report's capabilities to include stratified information as well. This process will take time and manpower. By December 2024, we will have an update on if this report could be utilized. Our Health Equity and Quality teams will continue to monitor the data and ensure that any disparities are addressed promptly. As an organization, we also determined that over the course of this year, January to December, we would monitor our diabetes measures and focus on achieving a 2% improvement in diabetes management from the previous year. In 2023 our final rate for this measure was 33.33%, our goal for 2024 is to meet 31.33% which is a 2% improvement from the previous year. Our ultimate mission is to empower our members to lead healthier and happier lives, and we are dedicated to making that a reality.
Focus Area: Community and Enrollee Engagement
Goal (1): Establish Community Roundtables in underserved communities where ABH LA members reside
Participants: Community Development Director, Community Cares Manager, and Health Equity Administrator
Strategy: ABHLA's Community Development team provides a pathway to include input from persons who represent the broad interest of the communities we serve, including those with special knowledge of public health issues and representatives of vulnerable populations served by the plan. ABHLA's facilitation of Community Roundtables focuses on identifying local health care concerns and working collaboratively with regional agencies to address broader socioeconomic issues in the focus areas. These events provide a platform for the plan and community-based organization leaders to review key data/metrics that assist with strategic discussion and open the pathway to continued collective discuss regarding barriers and opportunities.
Activity: Conduct quarterly Community Roundtable events in underserved areas where ABH LA members reside, to address health inequities specific to the local community
Measurable Objective: • Conduct quarterly Community Roundtable events (4 per year) • Community representation from each of the 9 regions are to be included in at least one event annually
Milestones to be Completed by December 2024: Conduct assessment of Community Roundtable events with detailed input from key stakeholders

ABHLA takes pride in connecting with our community-based organizations and members. Through these partnerships, we are able to offer a wide range of services and programs that cater to the unique needs of our diverse membership. By fostering a sense of community and collaboration, we are able to create a supportive environment where individuals can thrive and make positive changes in their health and well-being. So far, ABHLA has hosted several meetings and events to bring together our partners and members to discuss important issues and share resources. We host quarterly Enrollee Advisory Council meetings. The purpose of these meetings are to connect with our community members and enrollees, to have meaningful discussions related to concepts, program initiatives, identifying barriers and ways to address them from the member perspective. It is our duty to respect the opinions of all enrollees of the council. So far, we have had 2 meetings for the year. We anticipate 2 more by December 2024. As mentioned previously, these EAC meetings are held quarterly in different regions within the state. In addition to our EAC meetings, we have also hosted our 2nd annual Aetna CBO Expo. This event was held in April at the Tangipahoa African American Museum & Veterans Archives. The purpose of this event is to allow our community based organizations to connect with our Aetna Medicaid & Medicare outreach teams. This event had attendees from various CBOs and healthcare systems. As it relates to hosting an event with community representation from all 9 regions, ABHLA recently joined forces with our workforce initiatives team as the inaugural Medicaid health plan to launch a first-of-its-kind Community Resource Center (CRC) co-located with CVS's newest Workforce Innovation and Talent Center (WITC) in Baton Rouge. The grand opening was kicked off by a ribbon cutting ceremony and remarks by a number of CVS Health, Aetna, and community leaders. The event also included site tours and demonstrations. The new CRC provides the public, Aetna Medicaid members and workforce program participants onsite health needs assessments and education, help with navigating health benefits, access to computers and state-of-the-art teleconferencing, CPR and first aid training, and connections to a local network of care providers. Community based organizations and members from all 9 regions were invited and welcomed to come and learn about workforce initiatives and increase access to local health care services. The dedication of ABHLA towards empowering our members is reflected in our efforts to provide resources, support, and opportunities for personal growth. As the year progresses, we anticipate another large scale community event in November, ABHLA Bayou Classic Brunch. More details to come on this soon. CBOs from all 9 regions will be invited and encouraged to attend. Through these events, meetings, roundtables and initiatives, members are encouraged to take charge of their well-being and lead fulfilling lives.
Focus Area: Maternal and Child Health
Goal (1): Reduce maternal health disparities experienced by Black and LatinX member populations
Participants: Black and Latinx ABH LA member populations of child-bearing age throughout all 9 regions, Louisiana Doulas, ABH LA Network providers, Network Management Manager, Health Equity Administrator, Quality Management – Population Health Program Managers
Strategy: Implement targeted initiative in high need areas to reduce poor birth outcomes among Black women by increasing access to doula services, engaging fathers during prenatal and postpartum periods, increasing utilization of VABs, and deploying mental health tools
Activity: Develop and execute strategy to engage doulas in high need areas Partner with community-based organizations that focus on improving father involvement and support young men through mentorship during prenatal and postpartum periods. Market availability of Pyx Health and maternal tailored resources.
Measurable Objective: • Prenatal and Postpartum Care (PPC) to reach 50th percentile or show 2% improvement • Preterm Birth (PTB) Black population to reach 50th percentile or show 2% improvement

- Low Birthweight (LBW) Black population to reach 50th percentile or show 2% improvement.

Milestones to be completed by December 2024:
Launch pilot initiative in priority area by December 2024

ABHLA's goal is to reduce maternal health disparities experienced by Black and LatinX member populations. By targeting this specific issue, we aim to not only improve health outcomes for these populations, but to also address inequities that contribute to these disparities. Through targeted efforts, we are launching a partnership with Birthmark Doula Collective. Birthmark Doula Collective is a birth justice organization dedicated to supporting, informing, and advocating for pregnant and parenting people and their families in New Orleans. They offer childbirth education, birth doula and postpartum doula services and lactation support. Birthmark Doula Collective is a doula-owned cooperative, committed to birth justice. We anticipate piloting this service in one region, Region 1 or Orleans, Jefferson, St. Bernard, and Plaquemines Parishes. This pilot region will allow us to fine-tune our approach and tailor services to better meet the unique needs of the populations mentioned. By working closely with Birthmark Doula Collective, we hope to build a network of support that can address the root causes of maternal mortality disparities and ultimately improve the health outcomes for the mothers within these communities. Our intent is to have this partnership solidified and in motion by December 2024. In addition to working with Birthmark Doula Collective for in person doula services within region 1, at this time, ABHLA is offering virtual support for our members via the vendor, Pacify. Pacify is an evidence based telehealth mobile app and perinatal solution that provides 24/7 access to a national network of International Board Certified Lactation Consultants (IBCLC) and Doulas via live video consultation. Ideally, at some point, we would like to provide in-person doula services to all of our regions we service, however due to the shortage of doulas, we are using Pacify as our alternative method to provide our members with support and care. We are also having continuous conversations with the March of Dimes organization to discuss collaboration and doula support. Once our in-person doula program has been launched, members in region 1 will have access to Birthmark Doula Collective, while the additional 8 regions will continue utilizing the Pacify app. (until we are able to expand partnerships with in-person doulas across the state) All-in-all, our members are supported with resources.

Improving father involvement and supporting young men through mentorship during prenatal and postpartum periods is also a high area of focus for us. Through our community development department, we have identified a community based organization, Fathers on a Mission (F.O.A.M.), who aligns with our vision. F.O.A.M. is an organization that caters to empowering men to become better father figures within their community. They connect Fathers with workplace opportunities, community resources, and opportunities to build relationships. They also offer fatherhood meetings and classes. Although we have an existing relationship with this organization, our goal is to expand and incorporate strategic planning as it relates to specific meetings & classes available to ABHLA members/families. By December 2024, our goal is to have a collaborative event with F.O.A.M. addressing the importance of fatherhood and providing resources and tools to succeed.

As mentioned, providing our members with useful resources is a mission of ours. We also utilize Pyx Health, a virtual platform offering loneliness and social isolation technology solution focused on serving vulnerable populations and improving health outcomes. Pyx Health is also up and running with the pregnancy program. So far, we have had great outcomes and results. The best part of this program is that they do make outreach calls to pregnant members to provide support and connect them with resources. This personal touch has made a significant impact on the overall well-being of our pregnant members. Additionally, Pyx Health's technology allows us to track progress and tailor our services to better meet the needs of each member.

In efforts to monitor progress, we will also focus on 3 measures we believe will measure our progress: Prenatal and Postpartum Care (PPC), Preterm Birth (PTB) black population, Low Birthweight (LBW) black population. Our goal is to increase each measure by 2% improvement from the previous year or to reach the 50th percentile. (For Non-HEDIS measures, 2023 final rates are pending calculation by our National Team. We are pending the final report out of these measures)

Focus Area: Mental Health and Behavioral Health Services
Goal (1): Reduce mental health disparities in rural communities by expanding access to behavioral health services via telehealth
Participants: ABH LA members residing in rural Louisiana communities with limited access to behavioral health providers
Strategy: To reduce mental health disparities in rural communities, the ABH LA strategy focuses on enhancing access and appointment availability for behavioral health services through a multi-faceted approach. This includes continuous network enhancement activities, increasing provider training and webinars, expanding Telehealth services for counseling and medication management, actively engaging with rural communities and Community-Based Organizations to identify specific needs informed by community, member, and provider feedback, and leveraging multi-channel outreach campaigns with members.
Activity: Develop and launch a provider training and webinar program focused on rural mental health challenges, Set up Telehealth services for counseling and medication management Initiate engagement with rural communities and CBOs to gather insights on mental health needs.
Measurable Objective: • Conduct at least 10 training sessions/webinars for providers annually • Hold engagement meetings with a minimum of 4 rural communities/ CBOs annually
Milestones to be completed by December 2024: Establish an infrastructure to launch a provider training program, initiate Telehealth services, and engage communities and CBOs in rural service areas by December 2024
Reducing mental health disparities in rural communities is a crucial goal for us. We believe that by working together and focusing our efforts on closing community resource gaps, we can make a significant impact on the overall well-being of individuals in rural areas. Mental health disparities are a pressing issue that must be addressed, and we are dedicated to ensuring that everyone, regardless of their location, has equal access to the resources and support they need. The milestone we have dedicated to complete by December 2024 is to establish an infrastructure to launch a provider training program, initiate telehealth services, and engage CBOs in rural service areas. We are on the path to meeting this milestone. Currently, we have a vendor relationship with Trusted Provider Network, or TPN. Health. Through their platform, we provide trainings to all of our in-network providers. Between January through June, there have been 5 trainings available both live and on-demand, on various topics including mental and behavioral health. We anticipate continuous collaboration with TPN offering additional trainings to accommodate the educational needs of our rural health members by December 2024. (5+ trainings upcoming). Being able to provide virtual support is also a major benefit for our ABHLA members. We have partnered with OneTelemed, a Louisiana based telehealth provider that specializes in providing mental health services to underserved communities across our member populations. We ensure that OneTelemed uses innovative HIPAA compliant video/audio technology to connect individuals in need of appointments with licensed professionals. This proactive approach to healthcare delivery can serve diverse member populations and improve health outcomes. We take pride in working closely with community leaders and organizations to better understand the unique needs and challenges faced by our diverse member populations. By fostering a sense of community and collaboration, we are able to create a supportive environment where individuals can thrive and make positive changes in their health and well-being. The establishment of our community health councils has allowed us to connect with the rural populations. So far, we have had 2 meetings within 2 rural locations, in Evangeline Parish (Ville Platte, LA) and Assumption Parish (Napoleonville, LA). Our goal is to have 2 more by year end. We allow the members of these communities to bring forth their needs, concerns & ideas for collaboration. We discuss ABHLA services inclusive of our mental health and behavioral health resources. Our SDoH strategist also leads follow up meetings with each community health council to ensure progress is being made on the initiatives discussed. Our community development team also hosts a plethora of community based events in several regions across the state, rural areas included. In our Q1, we had 74 events, provided $170,000 in sponsorships, and provided 689 health screenings. We are effortlessly building trust and a healthy rapport with our members,

community based organizations, as well as provider partners. By December 2024, our goal is to provide a continuous update on the strides we are making to alleviate mental health disparities in rural communities.
Focus Area: Social Determinants of Health
Goal (1): Build culturally responsive programs and services to eliminate barriers to care related to SDoH to reduce disparities related to heart and mental health
Participants: Social Impact Team, Quality Management, Community Development, Network Management Manager, and Community CARES Manager
Strategy: Launch the Aetna Community CARES team and develop and implementing a data driven approach for identifying community resource strengths and needs, establishing Field Teams - focused on creating deep partnerships and collaborative, innovative solutions to improve the well-being of members and their communities; Develop and implement a Community Resource Directory with Member Portals – the Community resource directory will support care managers in referring members to local resources and tracking closed loop referral processes; and creating a tailored intervention through boots on the ground SDoH Field Teams to address BP and depression based on understanding of local needs and available community resources
Activity: Develop and implement a Community Resource Directory with Member portals with validated up to date community resources lists, Create tailored interventions through boots on the ground SDoH field teams Implement a targeted intervention with network providers that includes sharing member and community data identifying SDoH needs and increasing provider submission of z-codes
Measurable Objective: • Create 2 Community Health Councils • Show 5% improvement in community resource gaps related to SDoH needs from previous year baseline
Milestones to be completed by December 2024: Create at least 1 target Community Health Council in a high need area with CBOs providing support to priority member populations by December 2024
Aetna Better Health recognizes that many social, cultural, economic, and environmental factors can influence individuals and population health outcomes. Poverty, access to transportation, access to food and access to adequate housing are factors that the health plan evaluates when assessing community health needs. The Community Resource Directory (CRD) is an internal proprietary CVS Health/Aetna tool that hosts a nationwide, directory of community-based organizations and agencies providing services that can help address the social care needs for our members. The CRD is focused on tackling the social determinants of health through an organized database of community based resources. The Member Portal for the Community Resource Directory went live in Louisiana in January 2024. Through the portal, members will be able to complete a variety of tasks including but not limited to, searching for resources, saving resources to their profile, and adding notes to saved resources. With this enhanced feature, we hope to gain additional insights into member resource searches. Collaboration plays a crucial role in ABHLA's mission as we work tirelessly with community partners to address important issues affecting member communities. By fostering relationships built on trust and mutual respect, ABHLA is able to make meaningful impact on improving overall health outcomes. In 2024, we anticipate conducting 4 community health councils. We have successfully hosted 2 out of 4 events. Our first community health council event was held on May 15th in Evangeline Parish (Ville Platte, LA). The focus of this event was on transportation needs. Our SDoH Strategist used data from our SDoH platform, social scape, to provide information to the community. The second event was held on May 16th in Assumption Parish (Napoleonville, LA). Our SDoH Strategist presented materials and information regarding Health Literacy. Both community health councils have opened up an opportunity for continuous collaboration. Our SDoH Strategist is currently leading follow up workgroups with participants from each community health council. These gatherings have allowed for open communication and the sharing of best practices to ensure that our programs are meeting the needs of the communities we serve. We are planning to have 2 more community health councils by the end of December 2024.

ABHLA is also focusing efforts on our community resource gaps related to SDoH needs. We have determined that we will set a goal for ourselves, 5% improvement from our 2023 baseline of 17% community resource gaps closures. By December 2024 we hope to increase community resource gap closures to 22%. Through education, advocacy, and strategic partnerships, ABHLA is committed to achieving our goal and creating a more just and inclusive healthcare system for all. Together, we can make a difference in the lives of those most vulnerable in our community and ensure that everyone has access to the resources they need to thrive.

Cultural Responsiveness and Implicit Bias Training

2. Cultural Responsiveness and Implicit Bias Training
ABHLA created a curriculum with a vendor, TPN.health, to enhance provider cultural responsiveness with trainings on health equity, implicit bias, and social determinants of health, beyond Culturally and Linguistically Appropriate Services standard requirements. The Health Equity Administrator collaborates with TPN.health to identify specific topic areas to focus provider and community trainings and then leverages the provider network to market curriculum to provider communities. These trainings are also communicated through the ABHLA Provider Relations team, provider manual, provider website and newsletter, provider portal-Availity, e-mail and fax blasts, network contracting, Provider Advisory Council, CLAS Committee, and through the Quality Practice Liaisons (QPLs). Provider Health Equity Trainings will be offered live and on-demand throughout the tenure of ABH LA's relationship with TPN.health. Between January to June, there have been 5 trainings available both live and on-demand. We anticipate continuous collaboration with TPN offering additional trainings by December 2024. (5+ trainings upcoming) In addition, ABHLA staff are held accountable for completing Aetna's Striving for Health Equity 101 and Cultural Competency courses. Striving for Health Equity 101 helps educate and empower ABH staff, so that the organization can address health inequities together. During the course, participants learn about whole body health, health equity and barriers to health, health inequities and disparities, and Aetna's commitment to advancing health equity. The Health Equity Administrator works with the Learning and Performance management teams to ensure ABH LA staff complete these course's annually and within 90 days of hire. So far, between January to June, our data has shown that we have a 70% completion rate and 30% in progress rate for Striving for HE. We have an 84% completion rate, 5% in progress and 11% outstanding for ABHLA Cultural Competency. We are continuously working with all staff to get these training completed. We have had discussions with senior leadership and are working to provide a list of names to leaders regarding their staff who has not completed these courses. Our hope is to have all in-progress and outstanding courses completed by December 2024. ABHLA also utilizes a holistic approach in engaging all areas of the plan to increase awareness of the provider network. With the intention of building a diverse staff, ABHLA will be build training and resources that are aligned with Health Equity and our various CVS Colleague Resource Groups which are voluntary, colleague-led organizations that encourage personal and professional development, promote diversity, and serve as a resource to CVS Health. Members of CRGs often share a common affinity such as ethnicity, gender, cultural identity, focus or constituency.

Stratify MCO Results on Attachment H Measures

ABH submitted measure rates with stratification by race, ethnicity, and geography with the HEP submission.