LOUISIANA DEPARTMENT OF HEALTH

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

External Quality Review Technical Report

for

Aetna Better Health

March 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgments and Copyrights

1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

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

[1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 3, 2025.

[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 3, 2025.

health PIHP, CSoC contractor, to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2025 (July 1, 2024–June 30, 2025) are displayed in Table 1-1. Of note, no MCEs are exempt from EQR.

Table 1-1—Louisiana's Medicaid MCEs

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

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the *CMS EQR Protocols* released in February 2023.[3] For the SFY 2025 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about the quality, timeliness, and accessibility of healthcare services provided by each MCE. Table 1-2 depicts the EQR activities conducted for each plan type.

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

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

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 3, 2025.

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
	adequacy indicators, as set forth by the State. Additionally, this activity evaluates the accuracy of provider directory information submitted by the MCOs and determines appointment availability information by conducting telephone surveys among a sample of providers.				
Encounter Data Validation (EDV)	This activity validates the accuracy and completeness of encounter data submitted by an MCO.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan	✓	✓	✓
Consumer Surveys: CAHPS-A and CAHPS-C	This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
CAHPS Dental Survey	This activity reports the results of each PAHP's CAHPS Dental Survey for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys		✓	
Behavioral Health Member Satisfaction Survey	This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management (CM) services to determine the number of individuals, the types of conditions, and the impact that CM services have on members receiving those services.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
Quality Rating System (QRS)	This activity evaluates and applies a rating to measure the quality of care and performance of the MCOs to provide information to help eligible members choose an MCO.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs	✓		

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2025. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

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

Definitions

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

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 2025 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the 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 the overall quality, timeliness, and accessibility of 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[4]

Strengths

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

[4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2024–March 19, 2025, November 2025. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/LA_2025_QSE-Report_F1.pdf. Accessed on: Dec 3, 2025.

Louisiana Medicaid 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 still plans to include the requirement for a commitment to QI in the PAHP contract.

The EQRO has identified the following strengths:

- In support of Goal 3, "Facilitate patient-centered, whole-person care," the MCEs demonstrated strong adherence to PIP methodology, with most projects scoring 100 percent on critical validation elements and achieving *High Confidence* ratings related to proper study design, data collection, and intervention planning.
- In support of Goal 1, "Ensure access to care to meet enrollee needs," LDH has established comprehensive network adequacy standards and monitoring processes that support access to care, as demonstrated by strong performance across multiple plan types. All MCEs met or exceeded provider-to-member ratio requirements and key behavioral health timeliness standards, and the PIHP achieved *High Confidence* ratings across all validated indicators with full compliance on appointment access standards. These results reflect a solid oversight structure and a generally adequate provider network to support timely access to behavioral and medical services for most members statewide.

Recommendations

The EQRO has identified the following recommendations for the quality strategy:

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH:
  - Establish clear, system-level performance goals within the quality strategy to define the intended direction and outcomes of improvement efforts.
  - Select a streamlined, high-impact set of priority measures that will serve as key indicators of progress toward these goals, reducing the overall number of measures and focusing improvement on LDH's highest priorities.
  - Ensure all goals and objectives—including those related to PAHPs and PIHPs—are supported by corresponding performance measures within the quality strategy.
  - Define baselines for the selected priority measures to support ongoing measurement, monitoring, and evaluation of performance over time.
  - Refine the measure set by eliminating retired, not reportable, and not applicable measures.
  - Align the quality withhold incentive program with the streamlined priority measure set to ensure that financial incentives are focused on the measures most critical to advancing LDH's system-level performance goals.

  - Strengthen the quality withhold incentive program to be outcome focused, ensuring that withhold payments are earned for demonstrated improvement or sustained high performance on priority measures.

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH increase its quality strategy evaluation to a three-year period. The evaluation of the effectiveness of the quality strategy should be conducted within the previous three years.
- To target improvement in Goal 2, "Improve coordination and transitions of care," HSAG recommends that LDH work with the MCOs to improve follow-up after emergency department (ED) and hospital visits for mental health and substance abuse.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH work with the PAHPs to increase the percentage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) enrollees receiving preventative dental services.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH use Medicaid data and performance measure results to identify populations with low rates of preventive and screening services, and require targeted outreach and interventions from the MCEs to increase completion of recommended services.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends that LDH strengthen oversight of member-experience performance by aligning CAHPS priorities with the quality strategy's goals and requiring the MCEs to determine factors contributing to persistently low or stagnant CAHPS scores, and implement focused improvement strategies while promoting interventions shown to improve access, communication, and member engagement.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH require the MCEs to achieve and maintain accurate, complete, and up-to-date provider directories by establishing clear data quality standards, enforcing routine audits, and imposing corrective actions when minimum accuracy thresholds are not met.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH strengthen oversight and collaboration with the dental PAHPs to improve network adequacy in parishes that did not meet distance standards by developing targeted remediation plans, prioritizing recruitment in high-need areas, and implementing ongoing monitoring to ensure members can obtain timely dental care across urban and rural regions.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH strengthen monitoring and follow-through on corrective actions for recurring operational deficiencies related to non-emergency medical transportation (NEMT) timeliness and provider payment to ensure compliance with contract requirements and prevent member access barriers.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH collaborate with the MCEs and providers to improve timely access to prenatal and postpartum care and reduce preventable adverse birth outcomes. Efforts should focus on identifying and addressing barriers to early and continuous prenatal care, implementing provider-level interventions to promote appropriate delivery practices and reduce low-risk cesarean rates, and enhancing outreach and care coordination to support postpartum follow-up and healthy birth outcomes.

Actions on External Quality Review Recommendations

The EQRO identified the following recommendations for the quality strategy during the last review period, March 20, 2023–March 19, 2024. These recommendations included how LDH could target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 includes the recommendations that the EQRO made to LDH to support program improvement and progress in meeting the goals of the quality strategy. The State's responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Table 1-3—EQRO Recommendations and LDH Actions

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH identify a measure to align with the following objectives: • Ensure appropriate hospice onboarding and transitioning from palliative care to hospice. • Promote early initiation of palliative care to improve quality of life. • Promote health development and wellness in children and adolescents. • Advance specific interventions to address social determinants of health (SDOH). • Advance value-based payment arrangements and innovation. • Ensure members who are improving or stabilized in hospice are considered for discharge.	LDH has alternative mechanisms to monitor and track these objectives and declines to add new performance measures at this time.
To target improvement in Goal 3, "Facilitate patient-centered, whole person care," HSAG recommended that LDH include performance measures for the PAHPs and PIHP in the quality strategy.	LDH agrees with this recommendation and has made this change in the upcoming Quality Strategy revisions.
To target improvement in Goal 3, "Facilitate patient-centered, whole person care," HSAG recommended that LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.	LDH agrees and will incorporate the PAHPs into the MCO PIP process beginning in calendar year (CY) 2026. The PAHPs will use the same submission guidelines and timeline and will also attend quarterly PIP meetings.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH continue to work with the MCEs during PIP and Medicaid Advisory Committee (MAC) meetings to discuss best practices for performance measures. During these discussions, LDH could focus on specific performance	LDH currently works with the MCOs collaboratively during quarterly PIP meetings. LDH works with all MCEs at quarterly MAC meetings. The MAC consists of

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
measures in the quality strategy that have not met improvement objectives and target objectives.	MCE chief medical officers. Best practices are discussed frequently. In addition, LDH meets with the MCO CEOs and other support staff during quarterly business reviews to discuss recommendations and best practices.
To improve MCO performance in Goal 6, "Partner with communities to improve population health and address health disparities," HSAG recommended that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans (HEPs) and the progress being made through quality interventions to reduce health disparities.	LDH attends MCO quarterly QAPI Committee meetings, where its HEP components and progress being made toward HEP goals are discussed. LDH also reviews and approves the MCOs' QAPI Plan and related progress reports annually and provides feedback to the MCOs as needed. LDH also provides feedback to the MCOs on their twice-yearly HEP submissions.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.	LDH agrees. These updates were made in the pending revised Quality Strategy.
To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommended that LDH assess MCO failure to provide NEMT and have the MCOs implement interventions to improve provision of NEMT and ensure it is timely and accessible.	LDH agrees and also assesses MCO failure to provide NEMT and requires the MCOs to implement interventions to improve provision of NEMT and ensure it is timely and accessible.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH assess areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty. This assessment should identify root causes for noncompliance and then work to identify appropriate interventions to eliminate noncompliance and improve performance.	LDH agrees and already assesses areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty, including identifying root causes and planned interventions through a corrective action plan (CAP).
HSAG recommended that LDH report rates for the following measures included in Appendix B of the quality strategy: • *Enrollment by Product Line* • *Language Diversity of Membership* • *Race/Ethnicity Diversity of Membership*	MCOs are already required to report these measures. They are not included on the Medicaid Quality Dashboard because they are statistical in nature and not performance based.

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for Aetna Better Health (ABH) conducted with Louisiana Medicaid managed care throughout SFY 2025.

Validation of Performance Improvement Projects

ABH actively worked on PIPs throughout SFY 2025, and reported CY 2024 performance indicator results for PIP validation in January 2025. HSAG conducted PIP validation activities from February through April 2025. LDH required ABH to conduct PIPs on the following state-mandated topics during SFY 2025:

- *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*
- *Behavioral Health Transitions of Care*
- *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*

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 2024 NCQA national 50th percentile, which served as the benchmark. A total of 44 measures, comprising 185 measure indicators, were selected for analysis. Of the 185 measure indicators, 29 were excluded from comparisons to NCQA national 50th percentile benchmarks: five indicators were excluded from the analysis because they were not reported in Quality Compass for MY 2024; 24 indicators were excluded from the analysis because their rates were not percentages and a percentage point difference could not be determined.

Of the 156 HEDIS measures/measure indicators with an associated benchmark, ABH had 67 indicators that performed greater than the NCQA national 50th percentile benchmark, 54 that performed lower than the NCQA national 50th percentile benchmark, and one indicator that was not compared to the NCQA national 50th percentile benchmark because the reported rate was *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

During 2025, HSAG reviewed 14 standards which represented all federal standards pursuant to 42 CFR Part 438. HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions. For any standard demonstrating less than 100 percent compliance, the MCOs must develop a CAP to address each requirement found to not exhibit full compliance.

Table 1-4—Summary of CR Scores for the Review Period: CY 2024

Standard #	Standard Name	CY 2024	MCO Average Results
I	Enrollment and Disenrollment Requirements and Limitations	100%	85%
II	Member Rights and Confidentiality	100%	99%
III	Member Information	67%	69%
IV	Emergency and Poststabilization Services	100%	99%
V	Adequate Capacity and Availability of Services	71%	52%
VI	Coordination and Continuity of Care	92%	85%
VII	Coverage and Authorization of Services	100%	93%
VIII	Provider Selection	32%	70%
IX	Subcontractual Relationships and Delegation	50%	64%
X	Practice Guidelines	100%	97%
XI	Health Information Systems	100%	96%
XII	Quality Assessment and Performance Improvement	100%	100%
XIII	Grievance and Appeal Systems	97%	90%
XIV	Program Integrity	100%	97%
Total Compliance Score		**87%**	

Validation of Network Adequacy

Provider Directory Validation

LDH paused the provider directory validation (PDV) activity for CY 2024; therefore, the PDV results shown are aggregate results for the Quarter (Q)1 and Q2 CY 2025 activity only. Aggregate Q1 through Q4 results will be presented in the SFY 2026 EQR technical report. HSAG's PDV indicated that, overall, the aggregate Q1 and Q2 provider information maintained and provided by ABH was inaccurate. Table 1-5 provides a summary of the aggregate Q1 and Q2 findings from the study.

Table 1-5—Summary of PDV Findings

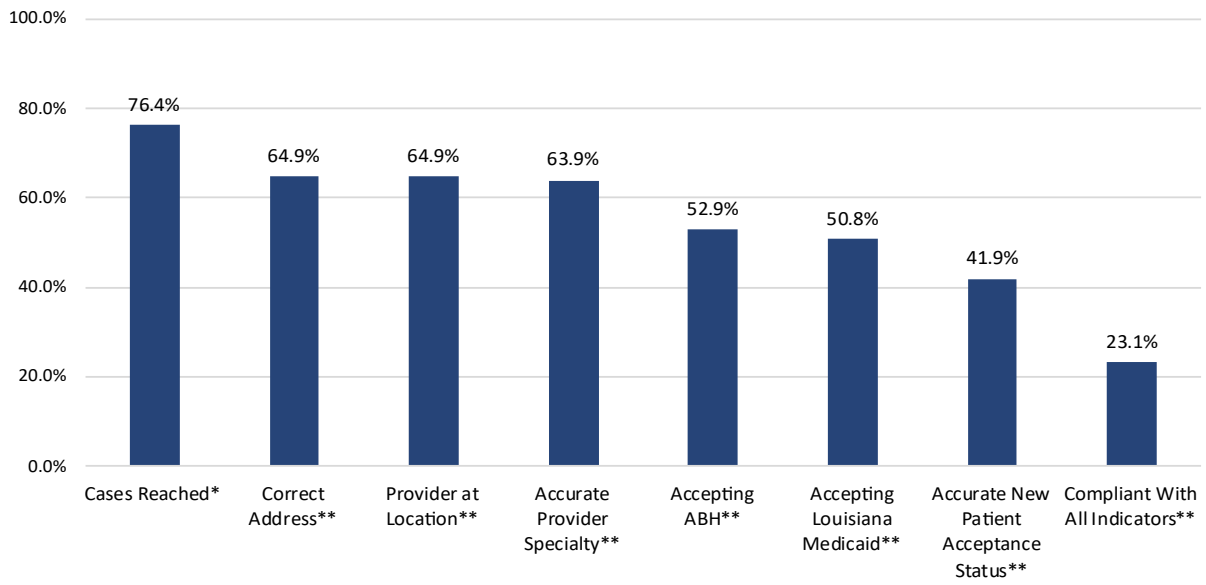
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 50.8 percent of providers accepted Louisiana Medicaid.
Acceptance of ABH was low.	Overall, 52.9 percent of providers accepted ABH.
Specialty provider type was incorrect in the provider directory.	Overall, 63.9 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall accuracy of the new patient acceptance status was low.[1]	Overall, 41.9 percent of providers confirmed the new patient acceptance status in the online provider directory was correct.
Affiliation with the sampled provider was low.	Overall, 64.9 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 64.9 percent of respondents reported that ABH's provider directory reflected the correct address.

[1]Since sampled cases were not limited to providers accepting new patients, match rates include respondents who confirmed the new patient acceptance status noted in the online provider directory was correct.

While the overall PDV response rate was relatively high at 76.4 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of the provider's new patient acceptance status, Louisiana Medicaid acceptance, and ABH acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate below 77.0 percent.

Figure 1-1 presents the aggregate Q1 and Q2 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 aggregate Q1 and Q2 weighted PDV compliance scores by specialty provider type ranged from 18.0 percent for behavioral health to 32.7 percent for pediatrics.

Provider Access Survey

LDH paused the provider access survey activity for CY 2024; however, HSAG conducted two surveys in CY 2025. The survey results shown in this report are for the first biannual 2025 survey only. HSAG's first provider access survey of 2025 indicated that, overall, the provider information maintained and provided by ABH was inaccurate. Table 1-6 provides a summary of the findings from the study.

Table 1-6—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 21.1 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 28.1 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, 28.1 percent of providers accepted Louisiana Medicaid.

Concerns	Findings
Acceptance of the MCO was low.	Overall, 29.8 percent of providers accepted the requested MCO.
Specialty provider type was inaccurate in the provider data.	Overall, 35.1 percent of providers confirmed the specialty listed in the provider data was accurate.
Address information was inaccurate.	Overall, 82.5 percent of locations confirmed the address listed in the provider data was accurate.

Table 1-7 presents the first provider access survey call outcomes.

Table 1-7—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]
Allergists	88.2%	86.7%	60.0%	60.0%	60.0%	60.0%	40.0%
Dermatologists	65.0%	76.9%	46.2%	38.5%	38.5%	38.5%	38.5%
Orthopedic Surgeons	70.7%	82.8%	17.2%	10.3%	6.9%	6.9%	3.4%
Total	**73.1%**	**82.5%**	**35.1%**	**29.8%**	**28.1%**	**28.1%**	**21.1%**

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

ABH's weighted first provider access survey compliance scores by specialty provider type ranged from 37.4 percent (orthopedic surgeons) to 52.9 percent (allergists).

NAV Audit

Table 1-8 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 1-8—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)	Rural
Pediatrics (Family/General Practice; Internal Medicine)	Rural
Federally Qualified Health Centers (FQHCs)	Rural
Rural Health Clinics (RHCs)	Rural
Pharmacy	Rural
Adult PCP (Family/General Practice; Internal Medicine)	Rural

Provider Type	Urbanicity
Neurology (Pediatric)	Rural
Ophthalmology	Rural
Orthopedics (Adult)	Rural
Orthopedics (Pediatric)	Rural
Otorhinolaryngology/Otolaryngology	Rural
Physicians and licensed mental health practitioners (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders	Rural
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders (SUD)	Rural
Psychiatric Residential Treatment Facilities (PRTFs) (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	Rural
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Rural

HSAG assessed ABH's results for statewide provider-to-member ratios by provider type and determined that ABH's statewide results met 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 1-9.

Table 1-9—ABH Appointment Access Standard Compliance Rates 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%	90%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	78%

Encounter Data Validation

Information Systems Review

The IS review provides self-reported qualitative information from ABH about its encounter data processes. Table 1-10 summarizes the strengths and weaknesses from the IS review. Cells with a "✓" indicate a strength, cells with an "X" indicate a weakness, and cells with an "—" indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

Table 1-10—Summary of Strengths and Weaknesses From IS Review

IS Review	ABH		Note
Encounter Data Sources and Systems	—		None.
Payment Structures	—		None.
Encounter Data Quality Monitoring			
Processes for Encounters Collected by Subcontractors	✓		Strengths were for dental, NEMT, pharmacy, and vision encounters.
Quality Monitoring on Encounters Collected by Subcontractors	✓		Strengths were for dental and NEMT encounters.
Quality Monitoring on Encounters Collected by ABH	—		None.
% of Encounters Initially Rejected and Not Yet Accepted by LDH	✓	X	Strength was for pharmacy encounters, and weakness was for vision encounters.

Administrative Profile

The administrative profile analyzes LDH's encounter data, for ABH, for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Table 1-11 summarizes the strengths and weaknesses stratified by encounter type. Cells with a "✓" indicate a strength, cells with an "X" indicate a weakness, and cells with an "—" indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

Table 1-11—Summary of Strengths and Weaknesses From Administrative Profile

Administrative Profile	Professional	Institutional	Dental	Pharmacy
Encounter Data Completeness				
Monthly Encounter Volume per 1,000 MM	—	—	—	—
Monthly Payment Amount PMPM	—	—	—	—
TPL Payment Amount PMPM	—	—	—	—
% of Duplicate Encounters	✓	✓	✓	✓

Administrative Profile	Professional	Institutional	Dental	Pharmacy
Encounter Data Timeliness				
Lag Between MCO Payment Date and Received Date by LDH	—	—	✓	✓
Field-Level Completeness and Accuracy				
% Present	—	—	X	—
% Valid	X	✓	X	X
Encounter Referential Integrity				
Encounter vs Enrollment	—			—
Medical/Dental vs Pharmacy Encounter	—			
Encounter vs Provider	X			X
Encounter Data Logic				
% of Members Who Had an Encounter	—	—	—	—
Member Enrollment Continuity	—	—	—	—

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

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared ABH's 2025 achievement scores to its corresponding 2024 achievement scores and the 2025 NCQA national averages to determine whether there were statistically significant differences.

Overall, ABH's 2025 adult achievement score was statistically significantly higher than the 2025 NCQA national average and the 2024 achievement score for *Rating of All Health Care*. Furthermore, ABH's 2025 adult achievement score was statistically significantly higher than the 2024 achievement score for *Rating of Health Plan*.

Behavioral Health Member Satisfaction Survey

HSAG compared ABH's 2025 achievement scores to the 2025 Healthy Louisiana statewide average (SWA) and 2024 scores to determine whether there were statistically significant differences.

Overall, ABH's adult and child achievement scores were not statistically significantly higher or lower than the 2024 achievement scores or Healthy Louisiana SWA; therefore, no strengths or opportunities for improvement were identified.

Case Management Performance Evaluation

During SFY 2025, HSAG conducted a review of the MCO's actions to address CAP findings, as identified during the SFY 2024 reviews.

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

HSAG will assess the MCO's implementation of remediation actions during the SFY 2026 reviews.

Quality Rating System

Figure 1-2 displays the 2025 Health Plan Report Card, which presents the 2025 rating results for each MCO. The 2025 Health Plan Report Card shows that ABH earned 4.0 stars for the Overall Rating. Additionally, ABH earned 4.0 stars for the Satisfaction with Plan Physicians, Satisfaction with Plan and Plan Services, Other Preventive Services, Diabetes, and Behavioral Health—Medication Adherence subcomposites, demonstrating strength for ABH in these areas. However, ABH earned 2.5 stars for the Respiratory and Behavioral Health—Care Coordination subcomposites and 2.0 stars for the Women's Reproductive Health subcomposite, demonstrating opportunities for improvement for ABH in these areas.

Figure 1-2—2025 Health Plan Report Card

Issued 07/2025

Healthy Louisiana

2025 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	★★★★	★★★★
PATIENT EXPERIENCE						
Overall Patient Experience	★★★½	★★★★	★★★★	★★★★	★★★★½	★★★½
Getting care: How easily and quickly did members get appointments, preventive care, tests, and treatments?	★★★	★★★½	★★★★	—	★★★★½	—
Satisfaction with plan physicians: How happy are members with their primary care doctors?	★★★★	★★★★★	★★★★½	★★★★	★★★★½	★★★½
Satisfaction with plan and plan services: How happy are members with their health plan and their overall care?	★★★★	★★★★½	★★★★	★★★★	★★★★½	★★★★
PREVENTION AND EQUITY						
Overall Prevention and Equity	★★★	★★★½	★★★½	★★★	★★★★	★★★½
Children/adolescent well-care: Do children and adolescents receive weight assessments?	★★★	★★★	★★★	★★★★	★★★★	★★★★
Women's reproductive health: Do women receive care before and after their babies are born?	★★	★★½	★★★	★★½	★★★★	★★★★

Continued on next page...

Figure 1-2—2025 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 members receive important cancer screenings?	★★★½	★★★½	★★★	★	★★★★½	★★★½
Equity: Do health plans collect race, ethnicity, and language information from their members?	★★★½	★★★★★	★★★★★	★★★★★	★★★★★	★★★½
Other preventive services: Do members receive important preventive services?	★★★★	★★★★	★★★★	★★★★	★★★★	★★★★
TREATMENT						
Overall Treatment	★★★½	★★★½	★★★	★★★	★★★½	★★★½
Respiratory: Do people with respiratory issues get the services/treatments they need?	★★½	★★½	★★★	★★★½	★★½	★★½
Diabetes: Do people with diabetes get the services/ treatments they need?	★★★★	★★★★½	★★★★	★★★★	★★★½	★★★★
Heart disease: Do people with heart disease get the services/ treatments they need?	★★★	★★★	★★	★★★	★★★★	★★★½
Behavioral health—care coordination: Do people with behavioral health issues get the follow-up care they need?	★★½	★★½	★★★	★★½	★★½	★★½
Behavioral health—medication adherence: Do people with behavioral health issues stay on prescribed medications?	★★★★	★★★	★★½	★★★½	★★★★	★★★★½
Behavioral health—access, monitoring, and safety: Do people on behavioral health medications receive the services/ monitoring they need?	★★★	★★★½	★★★★	★★★	★★★	★★★½

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Reduce low value care: Do members with low back pain receive unnecessary imaging tests?	★★★	★★★	★★★	★★	★★★	★★

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

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

This report card is reflective of data collected between January 2024 and December 2024.

The categories and measures included in this report card are based on the 2025 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. The Risk-Adjusted Utilization category was removed because changes in the way the data were calculated and reported prevented comparisons to national data. 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 2025 (review period) was the third 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 2025. Table 2-1 summarizes the PIP topics carried out by ABH in SFY 2025.

Table 2-1—SFY 2025 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• No restrictions
Behavioral Health Transitions of Care	• 6 years and older • 13 years and older
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• 6 months–18 months • 19 months–2 years • 3–5 years
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• 21–64 years
Screening for HIV Infection	• 13 years and older • 15–65 years

For each PIP topic, ABH collaborated on improvement strategies, meeting at least quarterly 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 2024 through June 2025, the end of SFY 2025.

Table 2-2—SFY 2025 MCO PIP Activities

PIP Activities and Milestones	Dates
Monthly collaborative PIP meetings with LDH, the MCOs, and HSAG	July–December 2024
The MCOs submitted Q2 2024 PIP updates	July 2024
The MCOs submitted Q3 2024 PIP updates	October 2024
Quarterly collaborative PIP meetings with LDH, the MCOs, and HSAG	January–June 2025
The MCOs submitted draft PIP reports to HSAG for validation	January 2025
The MCOs submitted Q1 2025 PIP updates	April 2025
HSAG provided draft PIP report validation findings to the MCOs	February 2025
The MCOs submitted final PIP reports to HSAG for validation	March 2025
HSAG provided final PIP validation reports to the MCOs	April 2025

In SFY 2026, ABH will submit draft PIP reports for initial validation in January 2026 and the final PIP reports for final validation in March 2026. HSAG will complete the third annual validation cycle in April 2026.

Validation Results and Confidence Ratings

Table 2-3 summarizes ABH's final PIP validation results and confidence ratings delivered by HSAG in April 2025.

Table 2-3—SFY 2025 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]
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	92%	88%	*Low Confidence*	*Not Assessed*[4]		
Behavioral Health Transitions of Care	93%	100%	*High Confidence*	75%	100%	*Moderate Confidence*
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	93%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	86%	78%	*Low Confidence*	100%	100%	*High Confidence*
Screening for HIV Infection	93%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

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

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

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

[4] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for the PIP.

Performance Indicator Results

Table 2-4 displays data for ABH's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

For Table 2-4 through Table 2-8, gray shaded cells with an — represent data that will be updated in future remeasurement years, and green shaded cells with a + represent any improvement over the baseline results.

Table 2-4—Performance Indicator Results for ABH's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
Syphilis screening during the first pregnancy examination.	N: 2,228 D: 2,559	87.07%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 759 D: 2,342	32.41%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 3 D: 2,560	0.12%	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 2,228 D: 2,560	87.03%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 1,533 D: 2,080	73.70%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 1,533 D: 2,560	59.88%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 1,684 D: 2,557	65.86%	— —	—	— —	—	*Not Assessed*

N–Numerator D–Denominator

*The syphilis screening at delivery rate is underreported due to bundled billing.

Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March 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 *Behavioral Health Transitions of Care* PIP.

Table 2-5—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%+	N: 636 D: 3,245	19.60%+ ▲	*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%+	N: 1,287 D: 3,245	39.66%+ ▲	*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%+	N: 102 D: 483	21.12%+	*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%+	N: 170 D: 483	35.20%+	*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%+ ▲	N: 155 D: 903	17.17%+ ▲	Yes
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%+ ▲	N: 257 D: 903	28.46%+ ▲	Yes

N–Numerator D–Denominator
▲ 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 activities, which occurred between January and March 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%	N: 207 D: 3,792	5.46%+	*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%	N: 369 D: 3,932	9.38%+ ▲	*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%	N: 245 D: 5,574	4.40%+	*Not Assessed*
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%	N: 821 D: 13,298	6.17%+ ▲	*Not Assessed*

N–Numerator D–Denominator

▲ 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 activities, which occurred between January and March 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%	N: 13,946 D: 26,922	51.80%+ ▲	— —	—	*Not Assessed*

N–Numerator D–Denominator
▲ 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 activities, which occurred between January and March 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%	N: 2,219 D: 3,254	68.19%+ ▲	— —	—	*Not Assessed*
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%	N: 3,050 D: 8,954	34.06%	— —	—	*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%	N: 5,259 D: 11,022	47.71%	— —	—	*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 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%	N: 25,524 D: 68,574	37.22%+ ▲	— —	—	*Not Assessed*

N–Numerator D–Denominator

Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March 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 2024 barriers and interventions.

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

PIP Topic	Barriers	Interventions
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• Lack of provider strategies for addressing stigma regarding syphilis screening during pregnancy	• Provider education on methods for reducing the stigma of syphilis screening when delivering prenatal care • Provider outreach/education on recommended timing of syphilis screening during pregnancy (first prenatal visit, early third trimester, and at delivery)
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge	• Improve timeliness of notification for hospital admission and discharge by increasing the number of hospital inpatient admissions for which the MCO received admit, discharge, transfer (ADT) data exchange for behavioral health-related emergency department (ED) visits and hospital stays

PIP Topic	Barriers	Interventions
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	• 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 • Enhanced enrollee outreach and education with dental provider appointment scheduling
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Enrollees are transient and cannot be contacted by either telephone call or mail	• Identifying and outreaching non-compliant enrollees through M-pulse to provide education and reminders to schedule cervical cancer screening appointments • Enrollee outreach through educational materials/trifolds and screenings during community events in various regions throughout the state
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Provided enrollees with educational materials on HIV statistics and HIV screening guidelines

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- 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 all four PIPs assessed for achieving significant improvement (*Behavioral Health Transitions of Care*, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*, *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*, and *Screening for HIV Infection*), all of the MCO's reported performance indicator results demonstrated some improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

- For one PIP assessed for achieving significant improvement (*Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees)*, all of the MCO's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For ABH, the following opportunities for improvement were identified:

- For two PIPs, *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* and *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*, the MCO revised the documented population descriptions, no longer aligning with the statewide PIP designs. **[Quality]**
- For one PIP, *Behavioral Health Transitions of Care*, the MCO revised the some of the Remeasurement 2 performance indicator data and did not provide an explanation or rationale for the revised data. **[Quality]**
- For two PIPs, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* and *Screening for HIV Infection*, the MCO did not report whether any factors were identified that may threaten the ability to compare remeasurement performance indicator results to baseline results. **[Quality]**

For ABH, the following recommendations were identified:

- The MCO should align the documented population description for each PIP with the statewide PIP design, and the description should remain unchanged for the duration of the project, to ensure comparability of results across measurement periods. **[Quality]**
- If the MCO revises previously reported performance indicator data, an explanation and rationale for the revisions should be included in the narrative interpretation of indicator results. **[Quality]**
- When interpreting the remeasurement results for the performance indicators for each PIP, the MCO should examine whether any factors were identified that threaten (a) the validity of the results and (b) the ability to compare the remeasurement results to baseline results. The MCO should report whether any factors were identified that threaten (a) validity and (b) comparability as part of the narrative interpretation of performance indicator results for each remeasurement period. **[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]**

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).[5]

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

1. HSAG evaluates the technical structure of the PIP to ensure that the 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.

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 3, 2025.

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 access to 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
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	✓	✓	✓
Behavioral Health Transitions of Care	✓	✓	✓
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 Infection	✓	✓	✓

3. Validation of Performance Measures

Results

Information Systems Capabilities Assessment

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, MY 2023, and MY 2024 Comparison

IS Standard	MY 2022	MY 2023	MY 2024
IS R—Data Management and Reporting (formerly IS 6.0, IS 7.0)	Met	Met	Met
IS C—Clinical and Care Delivery Data (formerly IS 5.0)	Met	Met	Met
IS M—Medical Record Review Processes (formerly IS 4.0)	Met	Met	Met
IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	Met	Met	Met

Performance Measures

In SFY 2025 (review period), LDH required each contracted MCO to collect and report on 44 HEDIS measures, which included 185 total measure indicators for HEDIS MY 2024 specified in the provider agreement. The measurement set included nine incentive measures: seven HEDIS and two non-HEDIS incentive measures. Table 3-2 through Table 3-4 display 179 of the 185 HEDIS measure indicators required by LDH, excluding six CAHPS measure indicators also required by LDH.

Table 3-2 through Table 3-5 display a summary of ABH's HEDIS measure performance. Red shaded cells with a **^** indicate that the measure fell below the NCQA national 50th percentile, while green shaded cells with a **+** indicate that the measure was at or above the NCQA national 50th percentile.

Table 3-2—ABH HEDIS Effectiveness of Care Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days of Discharge—Total	17.29%^	18.61%^	19.64%^	22.05%^
Within 30 Days of Discharge[I]—Total	35.27%^	37.03%^	39.66%^	42.18%^
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days of Discharge—Total	20.18%^	20.76%^	21.19%^	23.02%^
Within 30 Days of Discharge[I]—Total	33.57%^	33.39%^	35.81%^	38.77%^
Follow-Up After Emergency Department Visit for Substance Use				
Within 7 Days of Discharge—Total	22.24%^	15.38%^	18.19%^	15.66%^
Within 30 Days of Discharge[I]—Total	33.81%^	24.59%^	29.66%^	25.41%^
Follow-Up After High-Intensity Care for SUD				
Within 7 Days of Visit or Discharge—Total	—	—	60.04%+	59.23%+
Within 30 Days of Visit or Discharge—Total	—	—	71.90%+	70.77%+
Plan All-Cause Readmissions[B]				
*Observed Readmissions (Numerator/Denominator)**	10.37%	11.18%	11.02%	10.05%
Expected Readmissions Rate	9.79%	10.38%	8.78%	8.53%
*Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)**	1.0594^	1.0778^	1.2557^	1.1771^
Depression Screening and Follow-Up for Adolescents and Adults—Electronic Clinical Data System (ECDS)				
Depression Screening—Total	0.00%	0.78%^	6.47%+	3.31%^
Follow-Up on Positive Screen—Total	0.00%	83.33%+	94.56%+	73.57%+
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.33%+	85.69%+	86.44%+	85.11%+
Diabetes Monitoring for People With Diabetes and Schizophrenia	63.26%^	70.70%^	75.79%+	75.60%+
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.65%^	83.33%+	86.84%+	82.56%+
Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS				
Blood Glucose Testing—Total	—	—	52.57%^	53.68%^
Cholesterol Testing—Total	—	—	27.08%^	28.43%^
Blood Glucose and Cholesterol Testing—Total	—	—	25.30%^	27.26%^
Lead Screening in Children	62.04%^	67.64%+	71.53%+	70.87%+
Colorectal Cancer Screening[I]—ECDS	—	—	48.65%+	45.44%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile Documentation—Total	77.62%^	80.05%^	82.24%^	86.26%+
Counseling for Nutrition—Total	66.67%^	65.69%^	71.53%^	70.74%^
Counseling for Physical Activity—Total	62.29%^	63.50%^	70.32%+	66.86%^
HIV Viral Load Suppression[I]	80.62%	85.13%	84.27%	82.24%
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.67%	27.93%	25.63%	26.37%
Chlamydia Screening in Women				
Total	59.22%+	64.55%+	65.00%+	66.43%+
Controlling High Blood Pressure[I]	59.85%^	63.26%^	64.23%^	65.03%^
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	81.37%+	82.75%+	81.91%+	82.62%+
Statin Adherence 80%—Total	73.65%+	75.15%+	72.59%+	71.14%^
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status >9.0%[,I]*	33.09%+	33.33%^	25.79%+	28.35%+
Glycemic Status <8.0%	56.20%+	59.61%+	67.40%+	64.86%+
Eye Exam for Patients With Diabetes	52.31%+	46.96%^	58.64%+	59.29%+
Blood Pressure Control for Patients With Diabetes	61.31%^	62.29%^	68.86%^	69.65%^
Pharmacotherapy for Opioid Use Disorder	34.26%+	38.41%+	41.14%+	34.64%+
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total	60.02%+	61.26%+	61.47%+	59.26%+
Engagement of SUD Treatment—Total	25.54%+	26.94%+	28.84%+	27.37%+
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67.24%+	68.80%+	63.64%+	64.29%+
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.81%^	58.31%^	60.75%^	61.49%^
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—ECDS				
Initiation Phase	—	—	44.35%^	45.46%^
Continuation and Maintenance Phase	—	—	53.77%^	52.86%^
Antidepressant Medication Management				
Effective Acute Phase Treatment	60.92%+	61.92%^	66.52%+	60.88%^
Effective Continuation Phase Treatment	45.35%+	46.12% +	51.49%+	45.44%^

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	79.17%^	79.68%^	81.93%^	81.90%^
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	51.77%^	50.75%^	52.79%^	52.98%^
Use of Imaging Studies for Low Back Pain	69.73%^	67.96%^	68.30%^	68.86%^
Cervical Cancer Screening[I]	52.07%^	48.66%^	52.62%^	57.33%^
Asthma Medication Ratio				
5–11 Years	—	84.14%+	64.33%^	65.73%^
12–18 Years	—	85.71%+	72.62%+	63.52%^
19–50 Years	—	74.73%+	70.72%+	63.12%+
51–64 Years	—	81.82%+	75.54%+	65.14%+
Total	—	79.36%+	70.47%+	64.22%+
Appropriate Testing for Pharyngitis				
3–17 Years	—	—	85.64%^	82.73%^
18–64 Years	—	—	79.76%+	78.29%+
65 Years and Older	—	—	NA	60.61%+
Total	—	—	83.49%^	81.44%^
Topical Fluoride for Children				
1–2 Years	—	1.42%	1.63%	6.04%
3–4 Years	—	0.64%	0.65%	7.59%
Total	—	1.00%	1.13%	6.82%

[*] Indicates a lower rate is desirable.
[B] Indicates a break in trending between the most recent year and the prior year.
[I] Incentive Measure.
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/or MY 2023 and indicates that MY 2022 and/or MY 2023 rates are not available for those measures.

Table 3-3—ABH HEDIS Accessibility/Availability of Care Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	62.73%^	67.99%^	74.72%^	75.53%^
45–64 Years	75.53%^	80.95%^	83.88%+	83.48%+
65 Years and Older	71.82%^	68.44%^	76.24%^	77.97%^
Total	67.43%^	72.59%^	78.03%^	78.09%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	76.40%^	81.02%^	77.37%^	83.83%^
Postpartum Care	80.05%+	77.37%^	76.40%^	81.62%^

Table 3-4—ABH HEDIS Use of Services and Health Plan Descriptive Information Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Well-Child Visits in the First 30 Months of Life				
First 15 Months	58.55%+	68.42%+	66.87%+	64.83%+
15 Months–30 Months	61.09%^	70.22%+	71.07%^	72.42%+
Child and Adolescent Well-Care Visits^				
3–11 Years	50.72%^	54.70%^	58.14%^	60.45%^
12–17 Years	43.09%^	50.85%^	52.65%^	56.11%+
18–21 Years	22.79%^	27.60%^	30.77%^	32.68%+
Total	43.80%^	48.72%^	52.20%^	54.58%^
Antibiotic Utilization for Respiratory Conditions				
3 Months–17 Years	—	—	33.08%+	34.05%+
18–64 Years	—	—	27.99%+	29.16%+
65 Years and Older	—	—	19.12%+	20.07%+
Total	—	—	30.75%+	32.26%+
Enrollment by Product Line				
Less than 1 Year	—	2,691	3,184	37,522
1–4 Years	—	11,152	10,762	141,537
5–9 Years	—	14,314	14,248	182,737
10–14 Years	—	12,278	11,529	176,938
15–17 Years	—	7,821	7,468	109,211
18–19 Years	—	4,714	4,257	60,260
20–24 Years	—	11,250	9,202	111,685
25–29 Years	—	11,619	9,773	93,717
30–34 Years	—	11,975	10,596	92,906
35–39 Years	—	10,415	9,328	82,628
40–44 Years	—	9,114	8,146	72,625
45–49 Years	—	7,249	6,485	56,774

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
50–54 Years	—	6,982	5,949	48,838
55–59 Years	—	7,116	6,016	48,549
60–64 Years	—	7,057	6,106	48,032
65–69 Years	—	261	196	1,704
70–74 Years	—	86	68	620
75–79 Years	—	46	43	306
80–84 Years	—	NA	NA	200
85–89 Years	—	NA	NA	86
90 Years and Older	—	NA	NA	65
Unknown	—	NA	NA	NA
Total	—	136,199	123,405	1,366,940
Language Diversity of Membership				
Spoken Language Preferred for Health Care—Health Plan	—	0.00%+	0.00%^	51.08%+
Spoken Language Preferred for Health Care—CMS/State	—	100.00%+	100.00%+	47.98%+
Spoken Language Preferred for Health Care—Other Third-Party	—	0.00%+	0.00%+	0.94%+
Preferred Language for Written Materials—Health Plan	—	0.00%+	0.00%^	51.25%+
Preferred Language for Written Materials—CMS/State	—	100.00%+	100.00%+	24.75%+
Preferred Language for Written Materials—Other Third-Party	—	0.00%^	0.00%^	24.00%+
Other Language Needs—Health Plan	—	0.00%+	0.00%^	46.39%+
Other Language Needs—CMS/State	—	100.00%+	100.00%+	20.61%+
Other Language Needs—Other Third-Party	—	0.00%^	0.00%^	33.00%+
Spoken Language Preferred for Health Care—Percent English	—	0.00%^	98.14%+	97.19%+
Spoken Language Preferred for Health Care—Percent Non-English	—	0.00%^	1.81%^	1.86%^
Spoken Language Preferred for Health Care—Percent Declined	—	0.00%+	0.00%+	0.00%+
Spoken Language Preferred for Health Care—Percent Unknown	—	100.00%+	0.06%^	0.95%^
Language Preferred for Written Materials—Percent English	—	0.00%^	0.00%^	65.15%^
Language Preferred for Written Materials—Percent Non-English	—	0.00%^	0.00%^	1.31%^

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Language Preferred for Written Materials—Percent Declined	—	0.00%+	0.00%+	0.00%+
Language Preferred for Written Materials—Percent Unknown	—	100.00%+	100.00%+	33.54%+
Other Language Needs—Percent English	—	98.11%+	0.00%+	37.76%+
Other Language Needs—Percent Non-English	—	1.84%+	0.00%+	0.57%+
Other Language Needs—Percent Declined	—	0.00%+	0.00%+	0.00%+
Other Language Needs—Percent Unknown	—	0.06%^	100.00%+	61.67%^
Race/Ethnicity Diversity of Membership				
Race—Health Plan	—	0.00%+	0.00%^	44.31%+
Race—CMS/State	—	66.39%+	86.12%+	41.33%^
Race—Other Direct	—	0.00%+	0.00%+	1.69%+
Race—Direct Total	—	66.39%^	86.12%+	87.33%+
Race—Indirect Total	—	0.00%+	5.88%+	1.14%+
Race—Unknown Total	—	33.61%+	8.00%^	11.53%^
Ethnicity—Health Plan	—	0.00%+	0.00%^	35.42%+
Ethnicity—CMS/State	—	72.75%+	71.91%+	36.27%+
Ethnicity—Other Direct	—	0.00%+	0.00%+	9.66%+
Ethnicity—Direct Total	—	72.75%+	71.91%^	81.35%^
Ethnicity—Indirect Total	—	0.00%+	14.73%+	4.26%+
Ethnicity—Unknown Total	—	27.25%+	13.36%+	14.39%+
Race: White—Ethnicity: Hispanic or Latino	—	0.00%^	10.22%+	3.01%+
Race: White—Ethnicity: Not Hispanic or Latino	—	27.02%+	27.17%+	32.21%+
Race: White—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.01%+
Race: White—Ethnicity: Unknown	—	0.00%^	2.44%+	2.86%+
Race: White—Ethnicity: Total	—	27.02%^	39.83%^	38.09%^
Race: Black or African American—Ethnicity: Hispanic or Latino	—	0.00%^	12.72%+	3.34%+
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	31.94%+	29.26%+	37.02%+
Race: Black or African American—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Black or African American—Ethnicity: Unknown	—	0.14%^	3.55%+	3.99%+
Race: Black or African American—Ethnicity: Total	—	32.08%+	45.53%+	44.36%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	0.00%^	0.31%+	0.09%+
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	0.55%+	0.36%+	0.47%+
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	0.00%^	0.23%+	0.21%+
Race: American Indian or Alaska Native—Ethnicity: Total	—	0.55%+	0.90%+	0.77%+
Race: Asian—Ethnicity: Hispanic or Latino	—	0.00%^	0.63%+	0.12%+
Race: Asian—Ethnicity: Not Hispanic or Latino	—	0.00%^	1.03%^	1.53%+
Race: Asian—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Asian—Ethnicity: Unknown	—	6.61%+	0.32%+	0.40%+
Race: Asian—Ethnicity: Total	—	6.61%+	1.98%+	2.04%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	0.00%^	0.02%+	0.01%^
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	0.00%^	0.01%^	0.02%^
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	—	0.03%+	0.01%+	0.01%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	0.03%^	0.04%^	0.04%^
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	0.00%^	2.05%+	0.53%+
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	0.00%^	0.56%+	1.30%+
Race: Some Other Race—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Some Other Race—Ethnicity: Unknown	—	0.11%+	1.11%+	0.70%+
Race: Some Other Race—Ethnicity: Total	—	0.11%^	3.72%+	2.54%+
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%+	0.27%+
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	0.00%+	0.00%+	0.13%+
Race: Two or More Races—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: Two or More Races—Ethnicity: Unknown	—	0.00%+	0.00%+	0.24%+
Race: Two or More Races—Ethnicity: Total	—	0.00%+	0.00%+	0.64%+
Race: Unknown—Ethnicity: Hispanic or Latino	—	1.63%^	2.30%^	0.99%^
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	0.46%+	0.01%^	3.02%+
Race: Unknown—Ethnicity: Asked but No Answer	—	11.14%+	0.00%+	1.54%+
Race: Unknown—Ethnicity: Unknown	—	20.37%+	5.69%+	5.98%+
Race: Unknown—Ethnicity: Total	—	33.61%+	8.00%^	11.53%^
Race: Total—Ethnicity: Hispanic or Latino	—	1.63%^	28.24%+	8.36%^
Race: Total—Ethnicity: Not Hispanic or Latino	—	59.97%+	58.40%^	75.70%+
Race: Total—Ethnicity: Asked but No Answer	—	11.14%+	0.00%+	1.55%+
Race: Total—Ethnicity: Unknown	—	27.25%+	13.36%+	14.39%+
Race: Total—Ethnicity: Total	—	100.00%+	100.00%+	100.00%+
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Unknown	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Total	—	0.00%+	0.00%+	0.00%+

* Indicates a lower rate is desirable.
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/or MY 2023, and indicates that MY 2022 and/or MY 2023 rates are not available for those measures.

Table 3-5—ABH HEDIS Performance Measure Summary—MY 2022, MY 2023, and MY 2024 Comparison

Measure Status	MY 2022	MY 2023	MY 2024*
≥ NCQA National 50th Percentile Benchmark	20	163	94
< NCQA National 50th Percentile Benchmark	58	113	56
NCQA National Benchmark Unavailable	11	12	5
Total	**89**	**288**	**155**

* The "Total" row presents the count of all HEDIS measure indicators that could be reported by ABH for MY 2024, 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 2024, 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 rates on the *Follow-Up After High-Intensity Care for SUD* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ABH was effective in coordinating with providers to ensure that adolescent and adult members diagnosed with SUD who were discharged from an inpatient setting or visited a residential treatment or withdrawal management center received timely and adequate follow-up care to manage their conditions. **[Quality, Timeliness, and Access]**
- ABH's rates on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest 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 2024. 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 *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in ensuring that adult members with diabetes and schizophrenia were screened for diabetes and hade their diabetes monitored to promote 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 2024. 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 *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2024. 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 *Colorectal Cancer Screening—ECDS* measure was above the NCQA national 50th percentile benchmark for MY 2024. 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 *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in coordinating with providers to ensure that child and adolescent members are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**

- ABH's rate on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. 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 2024. These results suggest that ABH was effective in coordinating 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 *Eye Exam for Patients With Diabetes* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in coordinating 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 *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in coordinating 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* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ABH was effective in coordinating 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 2024. This result suggests that ABH was effective in coordinating 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 rates on the *Antidepressant Medication Management* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest 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 *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%* and *Glycemic Status >9.0%* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in coordinating with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- ABH's rates on the *Asthma Medication Ration—12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ABH effectively coordinated with providers to help adolescent and adult members with persistent asthma manage this treatable condition. **[Quality]**

- ABH's rate on the *Appropriate Testing for Pharyngitis—18–64 Years* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in coordinating with providers to ensure that adult members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**
- ABH's rate on the *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in coordinating with PCPs to ensure that adult members were engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- ABH's rate on the *Well-Child Visits in the First 30 Months of Life—First 15 Months* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH was effective in coordinating with PCPs to ensure that children were seen within the first 15 months of life to assess and influence members' early development. **[Quality and Access]**
- ABH's rates on the *Antibiotic Utilization for Respiratory Conditions* measure indicators were above the NCQA national 50th percentile benchmark. These results suggest that ABH was effective in coordinating with providers to ensure that members diagnosed with a respiratory condition were not inappropriately dispensed an antibiotic. **[Quality]**

For ABH, the following opportunities for improvement were identified:

- ABH's rates on the *Follow-Up After Hospitalization for Mental Illness* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. 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* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. Additionally, ABH's rates on the *Follow-Up After Emergency Department Visit for Substance Use* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. 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 2024. This result suggests that ABH has room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- ABH's rates on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ABH has room for improvement in coordinating with providers to ensure blood glucose testing and cholesterol testing are conducted for child and adolescent members on antipsychotics. **[Quality]**

- ABH's rates on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Nutrition—Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ABH has room for improvement in coordinating 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 *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2024. 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* measure was below the NCQA national 50th percentile benchmark for MY 2024. 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 2024. 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 rates on the *Follow-Up Care for Children Prescribed ADHD Medication—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest 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 *Appropriate Treatment for Children With URI* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH has room for improvement with ensuring that a diagnosis of 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 2024. This result suggests that ABH has room for improvement in 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 2024. This result suggests that ABH has room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- ABH's rate on the *Cervical Cancer Screening* measure was below the NCQA national 50th percentile benchmark for MY 2024. 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 rate on the *Asthma Medication Ration—5–11 Years* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH has room for

improvement in coordinating with providers to help child members with persistent asthma manage this treatable condition. **[Quality]**

- ABH's rates on the *Appropriate Testing for Pharyngitis—3–17 Years* and *Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that ABH has room for improvement in coordinating with providers to ensure that members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**
- ABH's rates on the *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *65 Years and Older*, and *Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. 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* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. 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 rate on the *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that ABH has room for improvement in coordinating with PCPs to ensure that children are seen after the first 15 months of life to assess and influence members' early development. **[Quality and Access]**
- ABH's rates on the *Child and Adolescent Well-Care Visits* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. 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*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* 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 (i.e., 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 indicator, HSAG recommends that ABH work with providers to improve post-discharge planning and care coordination. **[Quality]**

- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* 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 *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 (i.e., 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 *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 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* 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 (i.e., 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—ECDS* measure indicators, HSAG recommends that ABH work with providers to identify and address barriers to 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 *Appropriate Treatment for Children With URI* measure, HSAG recommends that ABH work with providers to trial solutions to reduce antibiotic dispensing to treat URIs. 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 *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 (i.e., 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 *Asthma Medication Ratio—5–11 Years* measure indicator, HSAG recommends that ABH work with providers to identify and address challenges with access to asthma medication or medication adherence in child members with persistent asthma. ABH could also consider expanding on existing strategies that focus on disease and chronic condition management, 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 best practices in asthma management. Additionally, ABH could consider data analysis and stratification across key demographics such as race, ethnicity, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Appropriate Testing for Pharyngitis—3–17 Years* and *Total* measure indicators, HSAG recommends that ABH work with providers to trial solutions to ensure that child and adolescent members diagnosed with pharyngitis are administered a group A streptococcus test to prevent the inappropriate prescribing of antibiotics. ABH could also consider data analysis and stratification across key demographics such as race, ethnicity, and ZIP Code to identify disparities and implement targeted interventions. **[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 (i.e., 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* 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 *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months* measure indicator, HSAG recommends that ABH work with providers to identify and address barriers to well-child visits for members after the first 15 months of life. ABH could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, 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-child visits. **[Quality 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-care visits. ABH could also consider data analysis and stratification across key demographics (i.e., 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,[6] 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

[6] 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 4, 2025.

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 2024 national 50th percentile Medicaid health maintenance organization (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 2024 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
Colorectal Cancer Screening—ECDS	✓		
Cervical Cancer Screening	✓		
Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge—Total and *Within 30 Days of Discharge—Total*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge—Total and *Within 30 Days of Discharge—Total*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge—Total and *Within 30 Days of Discharge—Total*	✓	✓	✓
Follow-Up After High-Intensity Care for SUD—Within 7 Days of Visit or Discharge—Total and *Within 30 Days of Visit or Discharge—Total*	✓	✓	✓
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0% and *Glycemic Status <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*	✓		✓
Plan All-Cause Readmissions—Observed Readmissions (Numerator/Denominator), *Expected Readmissions*, and *O/E Ratio (Observed Readmissions/Expected Readmissions)*	✓		
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—ECDS—Blood Glucose Testing—Total, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*	✓		
Chlamydia Screening in Women—Total	✓		
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—Total and *Engagement of SUD—Total*	✓	✓	✓
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—ECDS—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Appropriate Treatment for Children With URI	✓		

Performance Measure	Quality	Timeliness	Access
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Depression Screening and Follow-Up for Adolescents and Adults—ECDS—Depression Screening—Total and *Follow-Up on Positive Screen—Total*	✓		
Use of Imaging Studies for Low Back Pain	✓		
Asthma Medication Ratio—5–11 Years, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*	✓		
Appropriate Testing for Pharyngitis—3–17 Years, *18–64 Years*, *65 Years and Older*, and *Total*	✓		
Topical Fluoride for Children—1–2 Years, *3–4 Years*, and *Total*	✓		
Antibiotic Utilization for Respiratory Conditions—3 Months–17 Years, *18–64 Years*, *65 Years and Older*, and *Total*	✓		
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

Table 4-1 presents an overview of the results of the 2025 CR for ABH. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in the following Methodology section. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards.

Table 4-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	9	0	3	100%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	18	12	6	1	67%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	10	4	1	71%
VI	Coordination and Continuity of Care	12	12	11	1	0	92%
VII	Coverage and Authorization of Services	23	21	21	0	2	100%
VIII	Provider Selection	19	19	6	13	0	32%
IX	Subcontractual Relationships and Delegation	6	6	3	3	0	50%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	36	1	1	97%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		**227**	**217**	**189**	**28**	**10**	**87%**

M=*Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The **total** number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

MCO Strengths, Opportunities for Improvement, Required Actions, and/or Recommendations

For ABH, the following strengths were identified:

- ABH achieved a 100 percent compliance score for Standard I—Enrollment and Disenrollment Requirements and Limitations, demonstrating nondiscriminatory enrollment and contractually compliant disenrollment processes under LDH oversight. **[Quality and Access]**
- ABH achieved a 100 percent compliance score for Standard II—Member Rights and Confidentiality, demonstrating appropriate member rights protections, privacy practices, and confidentiality controls consistent with regulatory and contractual requirements. **[Quality and Access]**
- ABH achieved a 100 percent compliance score for Standard IV—Emergency and Poststabilization Services, demonstrating that it had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care. **[Quality, Timeliness, and Access]**
- ABH achieved a 100 percent compliance score for Standard VII—Coverage and Authorization of Services, demonstrating consistent and clinically driven authorization and adverse benefit determination (ABD) notification processes within required authorization time frames as well as compliance with coverage definitions and medical necessity and utilization management standards. **[Quality, Timeliness, and Access]**
- ABH achieved a 100 percent compliance score for Standard X—Practice Guidelines, demonstrating evidence-based adoption, annual review, provider involvement, LDH approval, broad dissemination, and consistent application in clinical and operational processes. **[Quality]**
- ABH achieved a 100 percent compliance score for XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]**
- ABH achieved a 100 percent compliance score for Standard XII—Quality Assessment and Performance Improvement, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; LDH-approved PIPs; and timely reporting to the LDH. **[Quality]**
- ABH achieved a 100 percent compliance score for Standard XIV—Program Integrity, demonstrating a compliant program integrity framework with strong governance; fraud, waste, and abuse (FWA) controls; timely overpayment and service verification processes; rigorous provider screening; and complete reporting and disclosures to LDH. **[Quality]**

For ABH, the following opportunities for improvement were identified:

- ABH's written materials for members did not meet reading grade level requirements, and materials critical to obtaining services did not meet criteria related to taglines, request for auxiliary aids and services at no cost, and the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number. **[Quality]**

- ABH did not make a good faith effort to give written notice within required time frames to members regarding termination of contracted providers. **[Quality, Timeliness, and Access]**
- ABH's paper provider directory was missing required components and not available in a machine-readable file format. **[Quality and Access]**
- ABH's website did not include language informing the member that information that is available in electronic form is available in paper form without charge upon request and that the MCE provides it upon request within five business days. **[Quality]**
- ABH was not monitoring its provider network to ensure adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. **[Quality and Access]**
- ABH did not require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**
- ABH did not ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- ABH did not ensure it offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. **[Quality and Access]**
- ABH's CMPE file review demonstrated noncompliance with timely completion of the initial health needs assessment. **[Quality and Timeliness]**
- ABH's CR demonstrated low compliance with Standard VIII—Provider Selection (32 percent). **[Quality and Access]**
- ABH did not ensure that all contracts or written arrangements comply—and that all delegates agreed to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- ABH did not demonstrate policy language that states if ABH extends the grievance resolution time frame not at the request of the member, ABH would make reasonable efforts to give the member prompt oral notice of the delay. **[Quality]**

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

- ABH must make sure written materials are available in formats consistent with State and federal regulations and in the prevalent non-English languages in its service areas. **[Quality]**
- ABH must make a good faith effort to give written notice of termination of a contracted provider, within required time frames, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. [**Quality, Timeliness, and Access]**

- ABH must include required components in its paper provider directory and provide it in a machine-readable file format. **[Quality and Access]**
- ABH must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days. **[Quality]**
- ABH must monitor, through the collection and analysis of data, its provider network to ensure adequate access to all services for all members, including those with limited English proficiency or physical or mental disabilities. **[Quality and Access]**
- ABH must meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**
- ABH must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- ABH must offer an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of members for the service area as well as maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. **[Quality and Access]**
- ABH must conduct an initial screening of each member's needs within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. **[Quality and Timeliness]**
- ABH must consult its CR results and develop its corrective actions related to provider selection. **[Quality and Access]**
- ABH must ensure that all contracts or written arrangements comply—and that all delegates agree to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- ABH must include policy language that states if ABH extends the grievance resolution time frame not at the request of the member, ABH would make reasonable efforts to give the member prompt oral notice of the delay. **[Quality]**

Methodology

Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the MCEs for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 4-2 outlines the division of standards reviewed for CY 2021, CY 2022, CY 2023, and CY 2024.

Table 4-2—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III—Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓
Standard VII—Coverage and	§438.210	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Authorization of Services											
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§438.608	✓	✓	✓				-	✓	✓	✓

[1] The CR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).
* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection

Prior to beginning the CR, HSAG developed data collection tools, referred to as "CR tools," to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs' compliance were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[7]

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an IS review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 4, 2025.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with the CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, CM, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for CM with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.

- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE's key staff members. Table 4-3 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 4-3—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025–September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual interviews conducted with key 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 the MCOs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of 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 accessibility of care and services provided by the MCOs. Table 4-4 depicts assignment of the standards to the domains of care.

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

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

Results

Provider Directory Validation

HSAG conducted Q1 and Q2 PDV reviews from January through April 2025 (review period). This section presents the aggregate results from the Q1 and Q2 CY 2025 PDV for all sampled ABH providers by specialty provider type.

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

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

Specialty Provider Type	Response Rate		Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Confirmed New Patient Acceptance Status[1]	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Internal Medicine/ Family Medicine	35	70.0%	28	80.0%	24	68.6%	23	65.7%	17	48.6%	15	42.9%	13	37.1%
Pediatrics	44	88.0%	29	65.9%	25	56.8%	25	56.8%	24	54.5%	24	54.5%	21	47.7%
Obstetricians/ Gynecologists (OB/GYNs)	42	84.0%	21	50.0%	33	78.6%	33	78.6%	25	59.5%	24	57.1%	20	47.6%
Specialists (any)	40	80.0%	27	67.5%	24	60.0%	24	60.0%	18	45.0%	18	45.0%	13	32.5%
Behavioral Health (any)	30	60.0%	19	63.3%	18	60.0%	17	56.7%	17	56.7%	16	53.3%	13	43.3%
Total	**191**	**76.4%**	**124**	**64.9%**	**124**	**64.9%**	**122**	**63.9%**	**101**	**52.9%**	**97**	**50.8%**	**80**	**41.9%**

[1] Sampled cases were not limited to providers accepting new patients. Match rates include respondents who confirmed the new patient acceptance status noted in the online provider directory was correct.

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

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

Specialty Provider Type	Total	Compliant[1]	Weighted Compliance Score
Internal Medicine/Family Medicine	50	10	22.7%
Pediatrics	50	13	32.7%
OB/GYNs	50	7	22.7%
Specialists (any)	50	7	19.3%
Behavioral Health (any)	50	6	18.0%
Total	**250**	**43**	**23.1%**

[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.

Provider Access Survey

HSAG conducted the first provider access survey from April to May 2025 (review period). This section presents the results from the first CY 2025 provider access survey for all sampled providers by MCO and specialty provider type.

Table 5-3 illustrates the response rate and indicator match rates for ABH by specialty provider type.

Table 5-3—Response Rate and Indicator Match Rates for ABH by Specialty Provider Type

Specialty Provider 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 (%)
Allergists	15	88.2%	13	86.7%	9	60.0%	9	60.0%	9	60.0%	9	60.0%	6	40.0%
Dermatologists	13	65.0%	10	76.9%	6	46.2%	5	38.5%	5	38.5%	5	38.5%	5	38.5%
Orthopedic Surgeons	29	70.7%	24	82.8%	5	17.2%	3	10.3%	2	6.9%	2	6.9%	1	3.4%
Total	**57**	**73.1%**	**47**	**82.5%**	**20**	**35.1%**	**17**	**29.8%**	**16**	**28.1%**	**16**	**28.1%**	**12**	**21.1%**

Table 5-4 illustrates the average new patient wait times and appointments meeting compliance standards for ABH by appointment type.

Table 5-4—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
Allergists	99	50.0%
Dermatologists	62	75.0%
Orthopedic Surgeons	0	100%

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

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

Specialty Provider Type	Total Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
Allergists	17	5	52.9%
Dermatologists	20	5	43.3%
Orthopedic Surgeons	41	1	37.4%
Total	**78**	**11**	**42.3%**

[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.
[2] The compliance scores in this section represent the weighted compliance score for each MCO and specialty and are not a calculation of the compliant providers divided by the total. The criteria in Table 5-11 and Table 5-12 of the Methodology section were used to calculate the weight of each noncompliance survey outcome.

NAV Audit

This section presents the results from the CY 2024 (review period) NAV audit.

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCE according to the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS

EQR Protocol 4).[8] Table 5-6 presents a summary of the NAV validation ratings for ABH by network adequacy standard type.

Table 5-6—Summary of ABH Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not be Validated
Time and Distance	100%	0%	0%	0%	0%
Provider-to-Enrollee Ratios	100%	0%	0%	0%	0%
Access and Availability	100%	0%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 96 indicators for ABH. Of these indicators, 100 percent received *High Confidence* ratings.

Access Standards

Table 5-7 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 in green and marked with an up arrow.

Table 5-7—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)	Urban	98.9%
	Rural	100% ↑
Pediatrics (Family/General Practice; Internal Medicine)	Urban	99.2%
	Rural	100% ↑
FQHCs	Urban	92.1%
	Rural	100% ↑
RHCs	Urban	84.5%
	Rural	100% ↑
Acute Inpatient Hospitals	Urban	85.9%
	Rural	96.9%
Laboratory	Urban	91.8%
	Rural	44.4%

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 4, 2025.

Provider Type	Urbanicity	Percentage of Members With Access
Radiology	Urban	99.1%
	Rural	99.4%
Pharmacy	Urban	98.4%
	Rural	100% ↑
Hemodialysis Centers	Urban	89.5%
	Rural	95.2%
OB/GYNs (access only for adult female members ages 21 and over)	Urban	97.8%
	Rural	98.7%
Allergy/Immunology	Urban	93.9%
	Rural	72.6%
Cardiology	Urban	99.9%
	Rural	100% ↑
Dermatology	Urban	99.9%
	Rural	95.2%
Endocrinology and Metabolism (Adult)	Urban	99.9%
	Rural	98.7%
Endocrinology and Metabolism (Pediatric)	Urban	99.9%
	Rural	99.1%
Gastroenterology	Urban	99.9%
	Rural	100% ↑
Hematology/Oncology	Urban	97.0%
	Rural	92.0%
Nephrology	Urban	99.7%
	Rural	99.1%
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	99.6%

Provider Type	Urbanicity	Percentage of Members With Access
Psychiatrists	Urban	96.5%
	Rural	95.8%
Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders	Urban	99.9%
	Rural	100% ↑
Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD	Urban	99.9%
	Rural	100% ↑
Behavioral Health Specialist (Advanced Practice Registered Nurse—Behavioral Health [APRN-BH] specialty, Licensed Psychologist, or Licensed Clinical Social Worker [LCSW])	Urban	99.3%
	Rural	99.8%
PRTFs (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21)	All	100% ↑
American Society of Addiction Medicine (ASAM) Level 1	Urban	94.2%
	Rural	95.6%
ASAM Level 2.1	Urban	94.2%
	Rural	90.1%
ASAM Level 2 WM	Urban	86.1%
	Rural	90.9%
ASAM Level 3.1 (Adult over age 21)	Urban	83.9%
	Rural	45.2%
ASAM Level 3.1 (Pediatric under age 21)	Urban	93.8%
ASAM Level 3.2 WM (Adult over age 21)	Urban	85.2%
	Rural	85.1%
ASAM Level 3.2 WM (Pediatric under age 21)	Urban	87.3%
ASAM Level 3.3 (Adult over age 21)	Urban	85.7%
	Rural	42.2%
ASAM Level 3.5 (Adult over age 21)	Urban	90.4%
	Rural	53.5%
ASAM Level 3.5 (Pediatric under age 21)	Urban	96.8%
ASAM Level 3.7 (Adult over age 21)	Urban	96.3%
	Rural	94.2%
ASAM Level 3.7 WM (Adult over age 21)	Urban	94.1%
	Rural	76.6%
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	100% ↑
	Rural	100% ↑

Provider Type	Urbanicity	Percentage of Members With Access
Mental Health Rehabilitation (MHR) Agency (Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention—MHR Agency [Legacy MHR], Behavioral Health Rehab Provider Agency [Non-Legacy MHR]; Mental Health Clinics)	Urban	95.8%
	Rural	94.7%

Provider-to-Member Ratios

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 5-8 displays the statewide combined adult PCP and combined pediatrics provider-to-member ratios.

Table 5-8—ABH Statewide Combined Adult PCP and Combined Pediatrics Provider-to-Member Ratios

Provider Type	Indicator	Compliant
Statewide Combined Ratio		
Combined Adult PCP Full-Time Equivalents (FTEs) (1:1,000 adult members)	3.15%	Yes
Combined Pediatrics (1:1,000 child members)	7.31%	Yes

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 5-9 displays the statewide provider-to-member ratios by specialty provider type and indicator.

Table 5-9—ABH Statewide Provider-to-Member Ratios by Specialty Provider Type

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
OB/GYNs	1:10,000	0.33%	Yes
Allergy/Immunology	1:100,000	0.02%	Yes
Cardiology	1:20,000	0.20%	Yes
Dermatology	1:40,000	0.06%	Yes
Endocrinology and Metabolism	1:25,000	0.03%	Yes
Gastroenterology	1:30,000	0.12%	Yes
Hematology/Oncology	1:80,000	0.03%	Yes
Nephrology	1:50,000	0.03%	Yes

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
Neurology	1:35,000	0.15%	Yes
Ophthalmology	1:20,000	0.14%	Yes
Orthopedics	1:15,000	0.19%	Yes
Otorhinolaryngology/Otolaryngology	1:30,000	0.11%	Yes
Urology	1:30,000	0.09%	Yes

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 5-10 displays the performance measure, threshold, LDH-established performance goal, and achieved compliance rate.

Table 5-10—ABH Appointment Access Standard Compliance Rates 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%	90%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	78%

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- No strengths were identified in the provider access survey and PDV, as all indicators had match rates below 90 percent.
- ABH demonstrated established operational controls across its data systems, including automated reconciliation of member enrollment files and structured workflows for provider data management through the provider relations management system and ProData. These processes supported timely updates and contributed to the overall accuracy of data used for network adequacy reporting. **[Quality and Timeliness]**

For ABH, the following opportunities for improvement were identified:

- Acceptance of ABH was inaccurate with 52.9 percent of providers in the PDV and 29.8 percent of locations in the provider access survey accepting ABH. Additionally, 50.8 percent of providers in the PDV and 28.1 percent of locations in the provider access survey accepted Louisiana Medicaid. **[Quality and Access]**
- Overall, only 63.9 percent of providers in the PDV and 35.1 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 41.9 percent of providers in the PDV and 28.1 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 64.9 percent of PDV locations and 21.1 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Of the limited number of cases that offered an appointment, 50.0 percent of allergist cases and 75.0 percent of dermatologist cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by survey type with overall compliance scores of 23.1 percent for the PDV and 42.3 percent for the provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with behavioral health having the lowest compliance score at 18.0 percent and pediatrics having the highest compliance score at 32.7 percent for the PDV. For the provider access survey, orthopedic surgeons exhibited the lowest compliance score at 37.4 percent, and allergists exhibited the highest compliance score at 52.9 percent. **[Quality and Access]**
- ABH generated GeoAccess tables and maps in preparation of the semiannual LA 220 report. However, three specialty provider types (i.e., Endocrinology/Metabolism, Neurology, and Orthopedics) were not mapped in accordance with LDH contractual requirements to report the adult and pediatric populations for distance reporting separately for these specialty provider types. **[Quality]**

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. **[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 timely. **[Timeliness and Access]**

- ABH should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active providers, telephone number, new patient acceptance). LDH could consider developing time frames and monitoring procedures (e.g., provider portals, data submissions) for ABH to confirm office outreach and confirmation of provider information. **[Quality and Access]**
- ABH should work with LDH to ensure clear understanding of the expectations to separate the reporting of adult and pediatric populations; this includes aligning with contractual standards and reporting expectations. Additionally, ABH should verify that all specialty data submissions meet LDH requirements before they are submitted. **[Quality]**

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. 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 January through April 2025. 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, specialty provider type, provider affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance status.

Provider Access Survey

HSAG conducted the first provider access survey from April to May 2025. 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 Identifier (NPI) number, specialty provider type, 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 specialty provider type 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 2025:

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 specialty provider type

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

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 5-11 were used to calculate the weight of each noncompliance survey outcome.

Table 5-11—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
New patient acceptance mismatch	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 provider type reported	1
Refused to participate in survey	0

Table 5-12—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 5-11. If multiple noncompliance criteria were 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 specialty provider type
- 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 5-13 were used to calculate the weight of each noncompliance survey outcome.

Table 5-13—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 provider type reported	1
Refused to participate in survey	0

Table 5-14—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 5-13. If multiple noncompliance criteria were 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 5-15.

Table 5-15—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 5-16.

Table 5-16—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 5-17 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-17—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 5-18.

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

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

6. Encounter Data Validation

Results

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

The administrative profile analyzed LDH's encounter data for completeness, timeliness, and accuracy by evaluating data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of LDH's data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 6-1 provides a list of multifaceted analyses conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of LDH's encounter data from ABH.

Table 6-1—EDV Results for ABH

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• ABH and its subcontractors demonstrated their capability to collect, process, and transmit encounter data to LDH, as well as develop data review and correction processes that can respond to quality issues identified by LDH. • ABH reported methods to identify duplicate claims. • ABH and its subcontractors were responsible for the collection and maintenance of the provider information. In addition, ABH and its subcontractors integrated the Medicaid member enrollment files into their systems for claim processing.
Payment Structures	• ABH reported a wide range of pricing methodologies that varied by encounter type and subcontractors. • ABH collected and verified TPL information, processed payment based on TPL information, and submitted TPL information to LDH via the encounter data.
Encounter Data Quality Monitoring	• ABH stated that it had subcontractors for dental, NEMT, pharmacy, and vision encounters. For the encounters collected by these

Analysis	Key Findings
	subcontractors, ABH noted that it stored and reviewed encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH. • ABH and/or its subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on these encounters collected by subcontractors except the claim volume checks on pharmacy and vision encounters. • For encounters collected by ABH, ABH noted that it performed completeness and accuracy, timeliness, and reconciliation with financial reports checks. • Based on ABH's responses to the questionnaire, the percentage of encounters that were initially rejected and not yet accepted by LDH varied from 0.3 percent (pharmacy encounters) to 6.2 percent (vision encounters).
Administrative Profile	
Encounter Data Completeness	• ABH displayed consistent encounter volume per 1,000 MM, payment amount PMPM, and TPL payment amount PMPM for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • ABH had a rate of duplicate encounters of less than 1.0 percent for each of the four encounter types listed above.
Encounter Data Timeliness	• Within 60 days, ABH submitted 97.7 percent of professional, 90.8 percent of institutional, 98.2 percent of dental, and 99.5 percent of pharmacy encounters to LDH after the payment date.
Field-Level Completeness and Accuracy	• All key data elements in ABH's encounter data had a relatively high or reasonable rate of population (i.e., percent present) except the Oral Cavity Code field for ABH's dental encounters. • ABH had all key data elements populated with at least 95.0 percent of valid values in institutional encounters, while there was at least one data element with an accuracy rate below 95.0 percent for the other three encounter types. Refer to the opportunities for improvement section below for the list of data elements needing ABH's attention.
Encounter Referential Integrity	• No major concerns were noted for ABH when evaluating the integrity between medical/dental/pharmacy encounters and member enrollment data, or between medical/dental encounters and pharmacy encounters. • Of all identified provider NPIs in ABH's submitted medical/dental and pharmacy encounters, only 85.4 percent and 74.5 percent were identified in the provider data, respectively.

Analysis	Key Findings
Encounter Data Logic	• ABH had 53.6 percent of members with both medical/dental and pharmacy encounters throughout the measurement year. • ABH had 63.9 percent of members who were continuously enrolled in the measurement year.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the encounters collected by its subcontractors, ABH noted that it stored and reviewed encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH. In addition, ABH and/or its dental and NEMT subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on the corresponding encounters. **[Quality and Timeliness]**
- ABH reported less than 1.0 percent of pharmacy encounters as initially rejected and not yet accepted. **[Quality]**
- ABH had a rate of duplicate encounters of less than 1.0 percent for each encounter type. **[Quality]**
- ABH submitted 98.2 percent of dental encounters and 99.5 percent of pharmacy encounters to LDH within 60 days from the payment date. **[Timeliness]**
- For institutional encounters, ABH had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**

For ABH, the following opportunities for improvement were identified:

- Among the five MCOs with a vision subcontractor, ABH had the second highest percentage of encounters initially rejected and not yet accepted by LDH at 6.2 percent. **[Quality]**
- The LDH-submitted data did not contain any values for the Oral Cavity Code field for ABH's dental encounters. **[Quality]**
- ABH had the following data elements with less than 95.0 percent of valid values: **[Quality]**
  - Professional Encounters: *Referring Provider NPI* (92.5 percent) and *National Drug Codes (NDCs)* (93.9 percent)
  - Dental: Rendering Provider NPI (91.3 percent) and Rendering Provider Taxonomy Code (80.2 percent)
  - Pharmacy: *Prescribing Provider NPI* (89.3 percent)

For referential integrity, among all MCEs, ABH had the lowest percentage of providers in the medical/dental encounter file who were also in the provider file, at approximately 85.4 percent. The percentage of providers in the pharmacy encounter file who were also in the provider file for ABH was also low, at approximately 74.5 percent. **[Quality]**

For ABH, the following recommendations were identified:

- ABH should build a process with LDH and its vision subcontractor to ensure that rejected vision encounters will be submitted to LDH with correct information. **[Quality]**
- For dental encounters, ABH should work with LDH to decide whether ABH should submit values (if any) for the Oral Cavity Code field to LDH. **[Quality]**
- ABH should investigate the root causes for data elements with less than 95.0 percent of valid values (i.e., those listed in the opportunities for improvement section) to improve accuracy. **[Quality]**
- ABH should work with LDH to ensure both entities have an accurate and complete database of contracted providers for medical/dental and pharmacy encounters. **[Quality]**

Methodology

Objectives

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, LDH requires its contracted Medicaid MCEs to submit high-quality encounter data. LDH relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2024–2025, LDH contracted with HSAG to conduct an EDV study consisting of the following two activities:

- IS review—assessment of LDH's and the MCEs' IS and processes. The goal of this activity was to examine the extent to which LDH's, and the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's [Managed Care Plan's] capability in the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).[9]
- Administrative profile—analysis of LDH's electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the electronic encounter data in LDH's data warehouse are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from January 1, 2023, through December 31, 2023. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

Technical Methods of Data Collection

Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- **Stage 1—Document Review:** HSAG conducted a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by LDH. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, LDH's current encounter data submission requirements, and other relevant materials. The information obtained

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 4, 2025.

from this review was important for developing a targeted questionnaire to address important topics of interest to LDH.

- **Stage 2—Development and Fielding of Customized Encounter Data Assessment:** HSAG first evaluated the MCEs' most recent ISCA, if available, to assess whether the information is complete and up to date. This process allowed these activities to be coordinated across projects, preventing duplication, and minimizing the impact on the MCEs. HSAG then developed a questionnaire customized in collaboration with LDH to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, this review included specific topics of interest to LDH. For example, the reviews included questions regarding how MCEs ensure their subcontractors are submitting timely, complete, and accurate encounter data.

  The questionnaire for LDH had similar domains; however, it focused on LDH's data exchange with the MCEs.

  HSAG created a different questionnaire for each MCE program (MCO, PAHP, PIHP) and submitted the appropriate questionnaire to each MCE to collect information. Additionally, since there were nine MCEs included in the study, HSAG distributed the questionnaire via an online tool to streamline collection of the responses.
- **Stage 3—Key Informant Interviews:** After reviewing responses to the questionnaires, HSAG followed up with key LDH and MCE information technology personnel to clarify any questions from the questionnaire responses.

Administrative Profile

HSAG assessed final adjudicated encounters with service dates from January 1, 2023, through December 31, 2023. In addition, the EDV study used member demographic/enrollment data and provider data to evaluate the validity of key data elements in the encounter data. HSAG used the monthly data extracts submitted by LDH's fiscal agent contractor (FAC) between January 2023 and December 2024 for the analysis.

Once HSAG received data files from LDH, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Percentage present—Required data fields were present on the file and had values in those fields.
- Percentage of valid values—The values were as expected (e.g., valid International Classification Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] codes in the diagnosis field).
- Referential integrity checks—Data sources could be joined with each other based on unique identifiers present in both data sources.

Once the final data were received and processed, HSAG conducted a series of analyses for five key metrics listed in the section below.

At a high level, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], 837 Dental [837D], and National Council for Prescription Drug Programs [NCPDP]). HSAG evaluated these metrics at the statewide level and by MCE. If results indicated data quality issue(s), HSAG conducted additional investigations to determine whether the issue was for a specific category of service (e.g., inpatient, nursing facilities), provider type (e.g., vision vendor, non-emergency transportation vendor), sub-population, etc. HSAG documented all noteworthy findings in the aggregate report.

Metrics for Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur): If the number of members remained stable and there were no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month may indicate incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key was based on the *Member ID*, *Rendering Provider NPI*, and *Date of Service* values.
- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each MCE based on the member enrollment data extracted by LDH.
- Paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from a payment perspective.
- TPL paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from the TPL payment perspective.
- Percentage of duplicate encounters

Metrics for Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by LDH within 360 days, from the payment date, in 30-day increments: This metric helps LDH to evaluate the extent to which the MCEs are in compliance with LDH's encounter data timeliness requirements (i.e., submit encounters within 30 days of adjudication).
- Claims lag triangle to illustrate the percentage of encounters received by LDH within two calendar months, three months, …, and such from the service month: This metric allows LDH to evaluate how soon LDH may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Metrics for Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters are complete and accurate through the two study indicators described in Table 6-2 for the key data elements listed in Table 6-3. In addition, Table 6-3 shows the criteria HSAG used to evaluate the validity for each data element. These criteria are based on standard reference code sets, or referential integrity checks against member or provider data.

Table 6-2—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table 6-3 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3. The criteria for validity are listed in Table 6-3.

Table 6-3—Key Data Elements for Percent Present and Percent Valid

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Member ID[H]	✓	✓	✓	✓	• In member file • Enrolled in a specific MCE on the date of service
Detail Service From Date[D]	✓	✓	✓		• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date[D]	✓	✓	✓		• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Date of Service[D]				✓	• Date of Service ≤ Paid Date

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Billing Provider NPI[H]	✓	✓	✓	✓	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider NPI[H]	✓		✓		• In provider data when service occurred • Meets Luhn check digit formula requirements
Attending Provider NPI[H]		✓			• In provider data when service occurred • Meets Luhn check digit formula requirements
Referring Provider NPI[H]	✓	✓	✓		• In provider data when service occurred • Meets Luhn check digit formula requirements
Prescribing Provider NPI				✓	• In provider data when service occurred • Meets Luhn check digit formula requirements
Rendering Provider Taxonomy Code[H]	✓		✓		• In standard taxonomy code set • Matches the value in provider data
Attending Provider Taxonomy Code[H]		✓			• In standard taxonomy code set • Matches the value in provider data

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Primary Diagnosis Codes[H]	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year (e.g., in 2023 code set for services that occurred between October 1, 2022, and September 30, 2023)
Secondary Diagnosis Codes[H]	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Codes/Current Dental Terminology (CDT) Codes[D]	✓	✓	✓		In national CPT, HCPCS, CDT code sets for the correct code year (e.g., in 2023 code set for services that occurred in 2023)
Procedure Code Modifiers[D]	✓	✓			In national standard code set or in the origin and estimation modifier list[10]
Tooth Number[D]			✓		In national standard code set
Tooth Surface[D]			✓		In national standard code set
Oral Cavity Code[D]			✓		In national standard code set
Primary Surgical Procedure Codes[H]		✓			In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes[H]		✓		.	In national ICD-10-CM surgical procedure code sets for the correct code year

[10] Healthy Louisiana. Medicaid Managed Care Entities System Companion Guide, Version 1, June 18, 2025. Available at: https://ldh.la.gov/assets/medicaid/MCE_System_Companion_Guide/HLA_MCE_SCG_v.1.pdf. Accessed on: Dec 4, 2025.

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Revenue Codes[D]		✓			In national standard revenue code sets for the correct code year
Type of Bill Codes[H]		✓			In national standard type of code set
National Drug Codes (NDCs)[D]	✓	✓		✓	In national NDC code sets
Submit Date[D]	✓	✓	✓	✓	MCE Submission Date (i.e., the date when the MCE submits encounters to LDH) ≥ MCE Paid Date
MCE Paid Date[D]	✓	✓	✓	✓	MCE Submission Date (i.e., the date when MCE submit encounters to LDH) ≥ MCE Paid Date
Detail Paid Amount[D]	✓	✓	✓	✓	Zero or positive
Detail TPL Paid Amount[D]	✓	✓	✓	✓	Zero or positive

[H] Conduct evaluation at the header level.
[D] Conduct evaluation at the detail level.

Metrics for Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that were present in both the encounter data and member enrollment files) through the key study indicators described in Table 6-4. If an encounter contained more than one NPI (e.g., attending provider NPI and billing provider NPI on an institutional encounter), HSAG included both unique NPIs in the analysis.

Table 6-4—Key Indicators of Referential Integrity

Data Source	Indicator
Medical/Dental Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter

Data Source	Indicator
Pharmacy Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Pharmacy Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Pharmacy Encounter
Medical/Dental Encounters vs Pharmacy Encounters	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Also Have a Pharmacy Encounter • Direction 2: Percentage of Members With a Pharmacy Encounter Who Also Have a Medical/Dental Encounter
Medical/Dental Encounters vs Provider File	• Direction 1: Percentage of Providers in the Medical/Dental Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical/Dental Encounter File
Pharmacy Encounters vs Provider File	• Direction 1: Percentage of Providers in the Pharmacy Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File

Metrics for Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG used logic-based checks to ensure the encounter data appropriately support additional activities.

- Percentage of members with a medical encounter, pharmacy encounter, both medical and pharmacy encounters, or neither from January 1, 2023, through December 31, 2023.
- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provided insight into how well encounter data may be used to support future analyses, such as HEDIS performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Description of Data Obtained

Information Systems Review

Representatives from each MCE completed the LDH-approved questionnaire and then submitted their responses and relevant documents via the UST to HSAG for review. Of note, the questionnaire included an attestation statement for each MCE's chief executive officer or responsible individual to certify that the information provided was complete and accurate.

Administrative Profile

Data obtained from LDH included:

- Claims and encounter data with dates of service from January 1, 2023, through December 31, 2023.
- Member demographic and enrollment data.
- Provider data.

How Data Were Aggregated and Analyzed

Information Systems Review

Questionnaire responses were collected and stored in a secure database maintained by HSAG. HSAG compiled responses from the received LDH- and MCE-specific questionnaires and assembled the information in Microsoft Excel workbooks. Responses were analyzed based on their relationship to the IS review EDV measures.

Administrative Profile

After consultation with LDH, HSAG used the data tables provided by LDH to create encounter, member demographic, member enrollment, and provider data files that contained the variables necessary for analysis. To analyze the data, HSAG prepared charts and figures to evaluate the pre-determined study metrics.

How Conclusions Were Drawn

Information Systems Review

HSAG made conclusions based on the CMS EQR Protocol 5, the MCE contracts, LDH's current encounter data submission requirements (e.g., companion guides), and HSAG's historical experience working with other states regarding the IS review.

Administrative Profile

To draw conclusions about the quality of each MCE's encounter data submissions to LDH, HSAG evaluated the results based on the predefined study and/or key metrics described above. To identify strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the MCEs' encounter data submissions to LDH. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to LDH.

Table 6-5—Assignment of EDV Measure Activities to the Quality, Timeliness, and Access Domains

EDV Measure	Quality	Timeliness	Access
IS Review: Encounter Data Sources and Systems	✓	✓	
IS Review: Payment Structures	✓		
IS Review: Encounter Data Quality Monitoring	✓	✓	
Administrative Profile: Encounter Data Completeness	✓		
Administrative Profile: Encounter Data Timeliness		✓	
Administrative Profile: Encounter Data Accuracy: Field-level Completeness and Accuracy	✓		
Administrative Profile: Encounter Data Referential Integrity	✓		
Administrative Profile: Encounter Data Logic	✓		

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

Results

Table 7-1 presents ABH's 2023, 2024, and 2025 adult achievement scores.

Table 7-1—Adult Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	76.09%	72.73%	81.48% ▲
Rating of All Health Care	75.68%	65.79%	83.58% ▲↑
Rating of Personal Doctor	84.56%	80.62%	81.94%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	NA	NA	81.08%
Getting Care Quickly	NA	NA	NA
How Well Doctors Communicate	91.80%	NA	94.95%
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 2025 score is statistically significantly higher than the 2025 NCQA national average.*
▲ *Indicates the 2025 score is statistically significantly higher than the 2024 score.*

Table 7-2 presents ABH's 2023, 2024, and 2025 general child achievement scores.

Table 7-2—General Child Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	86.45%	83.26%	83.43%
Rating of All Health Care	88.30%	88.22%	87.93%
Rating of Personal Doctor	92.27%	91.88%	91.38%
Rating of Specialist Seen Most Often	NA	91.51%	85.59%
Getting Needed Care	89.56%	86.23%	83.95%
Getting Care Quickly	86.59%	91.30%	88.77%
How Well Doctors Communicate	95.88%	94.91%	94.10%
Customer Service	NA	88.89%	90.97%

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).

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the adult population, ABH's 2025 achievement score was statistically significantly higher than the 2025 NCQA adult national average for one measure, *Rating of All Health Care*. **[Quality]**
- For the adult population, ABH's 2025 achievement scores were statistically significantly higher than the 2024 achievement scores for two measures: *Rating of Health Plan* and *Rating of All Health Care*. **[Quality]**
- For the general child population, ABH's 2025 achievement scores were not statistically significantly higher than the 2025 NCQA child national averages or the 2024 achievement scores for any measure; therefore, no substantial strengths were identified. **[Quality, Timeliness, and Access]**

For ABH, the following opportunity for improvement was identified:

- For the adult and general child populations, ABH's 2025 achievement scores were not statistically significantly lower than their corresponding 2025 NCQA national averages or ABH's 2024 achievement scores for any measure; therefore, no substantial weaknesses were identified. **[Quality, Timeliness, and Access]**

For ABH, the following recommendation was identified:

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

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

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 nonrespondents) 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 nonrespondents). 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 2025, 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.[11] 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."

[11] For this report, the 2025 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 2025 NCQA CAHPS adult and general child Medicaid national averages.[12]

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 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.[13] 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 2025 achievement scores were compared to their corresponding 2024 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2025 achievement scores and the 2024 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2025 than 2024 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2025 than 2024 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 2025 NCQA national average was denoted with a black upward arrow (↑).[14] Conversely, an MCO that performed statistically significantly lower than the 2025 NCQA national average was denoted with

[12] National data were obtained from NCQA's 2025 Quality Compass.

[13] 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.

[14] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2025.* Washington, DC: NCQA, September 2025.

a black downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2025 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 2025 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 7-3.

Table 7-3—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	✓		

8. Behavioral Health Member Satisfaction Survey

Results

Table 8-1 presents the 2023, 2024, and 2025 adult achievement scores for ABH and the Healthy Louisiana SWA.

Table 8-1—Adult Achievement Scores for ABH

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	56.12%	50.00%	53.08%	57.88%
How Well People Communicate	91.59%	90.41%	91.15%	91.16%
Cultural Competency	90.91%+	93.33%+	84.21%+	86.01%+
Helped by Counseling or Treatment	64.03%	62.86%	65.08%	70.38%
Treatment or Counseling Convenience	89.21%	85.00%	87.60%	88.13%
Getting Needed Treatment	75.91%	79.86%	75.19%	81.75%
Help Finding Counseling or Treatment	38.46%+	53.57%+	54.84%+	50.82%
Customer Service	57.89%+	65.00%+	54.17%+	70.81%
Helped by Crisis Response Services	63.64%+	77.78%+	76.19%+	72.26%

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.

Table 8-2 presents the 2023, 2024, and 2025 child achievement scores for ABH and the Healthy Louisiana SWA.

Table 8-2—Child Achievement Scores for ABH

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	52.63%+	61.40%+	65.91%+	63.63%
How Well People Communicate	93.12%+	91.95%+	92.86%+	91.03%
Cultural Competency	—	87.50%+	88.89%+	92.57%+
Helped by Counseling or Treatment	58.97%+	58.62%+	64.77%+	61.01%
Treatment or Counseling Convenience	97.44%+	82.76%+	87.21%+	88.86%
Getting Needed Treatment	79.49%+	74.55%+	77.91%+	78.93%
Help Finding Counseling or Treatment	37.50%+	28.57%+	41.67%+	38.57%+
Customer Service	50.00%+	42.86%+	75.00%+	71.71%+
Getting Professional Help	87.18%+	84.21%+	89.89%+	87.75%
Help to Manage Condition	87.18%+	86.21%+	84.27%+	83.38%

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 MCO's score was not reported due to insufficient data.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strength was identified:

- For the adult and child populations, ABH's 2025 achievement scores were not statistically significantly higher than the 2024 achievement scores or Healthy Louisiana SWA for any measure; therefore, no substantial strengths were identified. **[Quality, Timeliness, and Access]**

For ABH, the following opportunity for improvement was identified:

- For the adult and child populations, ABH's 2025 achievement scores were not statistically significantly lower than the 2024 achievement scores or Healthy Louisiana SWA for any measure; therefore, no substantial opportunities for improvement were identified. **[Quality, Timeliness, and Access]**

For ABH, the following recommendation was identified:

- HSAG recommends that ABH monitor the measures to ensure significant decreases in scores over time do not occur. **[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

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 2025.

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 2025 achievement scores were compared to their corresponding 2024 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2025 achievement scores and the 2024 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2025 than 2024 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2025 than 2024 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 accessibility of 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 8-3.

Table 8-3—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	✓		

9. Case Management Performance Evaluation

Results

During SFY 2025, HSAG conducted a review of the MCO's actions to address CAP findings, as identified during the SFY 2024 reviews. In addition, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the SFY 2026 CMPE.

The MCO successfully completed remediation actions to address the CAP findings, and the CAP was closed in October 2024.

HSAG will assess the MCO's implementation of remediation actions during the SFY 2026 reviews.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strength was identified:

- The MCO successfully completed remediation actions to address the CAP findings. **[Quality]**

For ABH, the following opportunity for improvement was identified:

- The MCO demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. **[Timeliness]**

For ABH, the following recommendation was identified:

- The MCO must continue the efforts documented in its CAP responses to ensure compliance with contractual requirements. **[Quality]**

10. Quality Rating System

Results

The 2025 (CY 2024) QRS results for ABH are displayed in Table 10-1.

Table 10-1—2025 (CY 2024) QRS Results for ABH

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

*This rating includes all measures in the 2025 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.

Please note that HSAG removed the *Plan All-Cause Readmissions* (PCR) measure and the Risk-Adjusted Utilization subcomposite from the 2025 report card analysis because NCQA recommended a break in trending so comparisons to the national average could not be performed.

ABH earned an Overall Rating of 4.0 stars, with 3.5 stars for the Patient Experience composite, 3.0 stars for the Prevention and Equity composite, and 3.5 stars for the Treatment composite.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the Patient Experience composite, ABH earned 4.0 stars for the Satisfaction with Plan Physicians and Satisfaction with Plan and Plan Services subcomposites. Both subcomposites are based on ABH member responses to CAHPS survey questions, demonstrating ABH members are satisfied with their providers and their health plan and the services it provides. **[Quality]**
- For the Prevention and Equity composite, ABH earned 4.0 stars for the Other Preventive Services subcomposite, demonstrating strength for ABH related to providing chlamydia screenings for young women. **[Access]**
- For the Treatment composite, ABH earned 4.0 stars for the Diabetes and Behavioral Health—Medication Adherence subcomposites, demonstrating strength for ABH related to diabetic care and ensuring members with depression and opioid use disorder stay on prescribed medications. **[Quality, Timeliness, and Access]**

For ABH, the following opportunities for improvement were identified:

- For the Prevention and Equity composite, ABH earned 2.0 stars for the Women's Reproductive Health subcomposite, demonstrating opportunities for improvement for ABH related to women receiving timely prenatal and postpartum care. **[Quality, Timeliness, and Access]**
- For the Treatment composite, ABH earned 2.5 stars for the Respiratory and Behavioral Health—Care Coordination subcomposites, demonstrating opportunities for improvement for ABH related to antibiotic use for bronchitis/bronchiolitis and ensuring members receive timely follow up after hospitalizations and ED visits for behavioral health conditions. **[Quality, Timeliness, and Access]**

For ABH, the following recommendation was identified:

- The MCEs were directed to reference the recommendations made for PMV and CAHPS as the Health Plan Report Card reflects HEDIS and CAHPS results. HSAG did not make additional recommendations specific to the QRS activity.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the six Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, HUM, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. The 2025 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 2024 CAHPS member-level data files and HEDIS IDSS data files from LDH and the six MCOs. The *HEDIS MY 2024 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2024 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 2024 (MY 2023) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[15]

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 2025 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[16,17]

- Overall
- Patient Experience
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan and Plan Services

[15] 2024 (MY 2023) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by August 5, 2025, and 2025 (MY 2024) Quality Compass national Medicaid ALOB benchmarks were not available until August 29, 2025.

[16] NCQA. 2025 Health Plan Ratings Required HEDIS, CAHPs, and HOS Measures. Available at: https://wpcdn.ncqa.org/www-prod/2025-HPR-List-of-Required-Performance-Measures_April-2025-Update.pdf. Accessed on: Dec 4, 2025.

[17] Please note that eight measures from NCQA's Health Plan Ratings measure list were not included in the 2025 report card measure list given that the MCOs are not required to report them for MY 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 2025 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2024 (MY 2023) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 10-2. For the *Race/Ethnicity Diversity of Membership*, *Language Diversity of Membership*, and *Plan All-Cause Readmissions* measures, HSAG followed NCQA's methodology for scoring race/ethnicity diversity measures, language diversity measures, and risk-adjusted utilization measures, respectively.

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 2025 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 2025 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	
PIP	• For four of five PIPs, ABH achieved significant improvement, and all reported performance indicator results demonstrated some improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
PMV	• ABH was effective in ensuring that adult members on antipsychotics and adult members with diabetes and schizophrenia were screened for diabetes had their diabetes monitored. **[Quality]** • ABH was effective in coordinating with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, initiate treatment for members with a new SUD episode, and engage these members in subsequent SUD services or medications. **[Quality]**
Compliance	• ABH scored 100 percent for eight standards in the CR, indicating that ABH's policies and procedures were generally compliant with contract requirements, and staff were generally knowledgeable about the requirements, policies, and procedures. **[Quality]**
NAV	• ABH established operational controls across its data systems, including automated reconciliation of member enrollment files and structured workflows. These processes support timely updates and contributions to the overall accuracy of data. **[Quality and Timeliness]**
EDV	• ABH submitted 98.2 percent of dental encounters and 99.5 percent of pharmacy encounters within 60 days from the payment date. **[Timeliness]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For the adult CAHPS population, ABH's 2025 CAHPS achievement score was statistically significantly higher than the 2025 NCQA adult national average and ABH's 2024 achievement scores for *Rating of Health All Health Care*. **[Quality]** • For the Behavioral Health Member Satisfaction Survey, no notable strengths were identified. **[Quality]**
CMPE	• ABH successfully completed remediation actions to address the CAP findings. **[Quality]**

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

Overall MCO Opportunities for Improvement	
PIP	• ABH did not achieve significant improvement outcomes for all PIPs. **[Quality]**
PMV	• ABH had room for improvement to ensure that members hospitalized or accessing the ED for mental illness receive adequate follow-up care. **[Quality, Timeliness, and Access]** • ABH had room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics to children with URIs and adults with bronchitis or bronchiolitis. **[Quality]**
Compliance	• ABH scored 50 percent for Standard IX—Subcontractual Relationships and Delegation, demonstrating the need to ensure that all contract or written arrangements include State and federal requirements. **[Quality]** • ABH scored 32 percent for Standard VIII—Provider Selection, demonstrating the need to improve credentialing and recredentialing processes. **[Quality]** • In the CR, ABH scored 32 percent for Standard VIII—Provider Selection, demonstrating the need to improve compliance with PSV requirements during credentialing and recredentialing. **[Quality]**
NAV	• No strengths were identified in the provider access survey and PDV, as all indicators had match rates below 90 percent. The provider access survey demonstrated low compliance (42.3 percent). The PDV revealed several opportunities for improvement related to accuracy of specialty provider type and accuracy of acceptance of ABH, Louisiana Medicaid, and new patients. **[Quality and Access]**
EDV	• For referential integrity in the EDV study, among all MCEs, ABH had the lowest percentage of providers in the medical/dental encounter file who were also in the provider file at approximately 85.4 percent. The percentage of providers in the pharmacy encounter file who were also in the provider file for ABH was also low at approximately 74.5 percent. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For both CAHPS and the Behavioral Health Member Satisfaction Survey, no substantial improvements were identified. **[Quality, Timeliness, and Access]**
CMPE	• ABH demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. **[Timeliness]**

Table 11-3—Recommendations

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
PIP	• To facilitate significant outcomes improvement for all PIPs, ABH should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. ABH should also revisit barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality]**	Goal 4: Promote wellness and prevention
PMV	• ABH should work with providers to identify barriers and improve coordination of follow-up care following discharge from the hospital or ED for members with mental illness. **[Quality and Access]** • ABH should work with providers to prevent or reduce antibiotic dispensing to treat URIs in children and adults with bronchitis or bronchiolitis. **[Quality]**	Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention
Compliance	• ABH must ensure that all contract or written arrangements include State and federal requirements. **[Quality]** • ABH must ensure its credentialing and recredentialing processes comply with State and federal requirements. **[Quality]** • ABH must ensure compliance with all PSV requirements during the credentialing and recredentialing process. **[Quality]** • ABH must complete its CAP to resolve all *Not Met* findings from the CR.	Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
NAV	• In addition to updating provider information, ABH should conduct a root cause analysis to identify the	Goal 1: Ensure access to care to meet enrollee needs

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
	nature of the data mismatches for PDV. **[Quality]** • ABH should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators. **[Quality]**	
EDV	• ABH should investigate the root causes for data elements with less than 95.0 percent of valid values (i.e., those listed in the opportunities for improvement section) to improve accuracy. **[Quality]** • ABH should work with LDH to ensure subcontractors have an accurate and complete database of contracted providers for medical/dental and pharmacy encounters. **[Quality]**	Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
CAHPS and Behavioral Health Member Satisfaction Survey	• ABH should monitor the CAHPS and Behavioral Health Member Satisfaction Survey measures to ensure significant decreases in scores over time do not occur. **[Quality]**	Goal 3: Facilitate patient-centered, whole-person care
CMPE	• ABH should continue the efforts documented in its CAP responses to ensure compliance with contractual CM requirements. **[Quality and Timeliness]**	Goal 2: Improve coordination and transitions of care

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 2023–2024 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 2024 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

Recommendation
To facilitate significant outcomes improvement for all PIPs, HSAG recommended 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.
Response
Describe initiatives implemented based on recommendations: ABHLA begins each performance improvement project (PIP) by reviewing all information associated with its launch, including the charter and main PIP document. The Performance Indicators (PI) are the focus of the PIP as they define the metrics that guide improvement efforts and ensure that the interventions are aligned with desired outcomes. After the performance indicators (PIs) are reviewed, focus transitions to the specified interventions. These encompass particular actions or inputs designed to affect the PIs and are characterized as factors intended to influence their outcomes. Some interventions are established by LDH and some are developed by MCOs to address barriers identified during the initial PIP or through ongoing experience. For example, to ensure providers do not lack awareness of updated protocols, such as the CDC's 2022 change lowering the HIV screening age from 15 to 13, MCOs designed targeted interventions, including provider educational materials, and tracked data to ensure positive outcomes. ABHLA begins each PIP with LDH defined interventions as well as MCO defined metrics. Each intervention is monitored for at least one year to assess its effectiveness and identify opportunities for refinement. At the end of the measurement year, ABHLA reviews all ITMs to determine which require modification due to changes in tools, processes, or best practices. Adjustments are made at the start of the new measurement year, while LDH-defined interventions continue as specified. This approach allows ABHLA to learn from implementation, identify what works, and develop improved strategies for sustained outcomes. For barriers addressed through interventions, ABHLA evaluates results to

determine whether enhancements or replacements are needed to maximize impact. Continuous measurement and refinement ensure that interventions remain effective and responsive to emerging challenges.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
As noted above, once interventions are implemented and initial improvements are observed in the associated metrics and overall PIs, ABHLA conducts an end-of-year review to determine whether adjustments are needed to sustain progress. For example, the text campaign for the BH TOC PIP initially drove significant improvement in FUA/FUM rates. However, over the following two years, performance plateaued. In response, we are exploring alternative strategies to educate and engage members about provider follow-up.

Historical data shows the campaign was effective early on, but its impact diminished as members became accustomed to the messaging. To address this, ABHLA is evaluating other outreach methods, such as personalized communication and multi-channel engagement, to improve not only message delivery but also member action. These insights are gathered and analyzed throughout the year, and decisions on modifications are incorporated into the annual report to ensure continued positive outcomes for our members.

Identify any barriers to implementing initiatives:
For member outreach interventions, one key barrier is maintaining accurate contact information, including correct phone numbers for calls and text messages. To address this, ABHLA is implementing multiple delivery methods, such as email, mail, and digital platforms to increase the likelihood of successful contact and member engagement. This multi-channel approach improves the chances of reaching members and driving action.

Another barrier is member follow-through on screenings and appointments. To overcome this, ABHLA is exploring enhanced reminder systems, personalized messaging, and education on the importance of completing care steps to improve compliance.

Provider engagement also presents challenges due to competing priorities and time constraints. Our strategy focuses on educating providers about outcome metrics and communicating available incentives, while emphasizing evidence-based practices that improve patient health. For example, we highlight the importance of syphilis screening in pregnant members to prevent lifelong complications in newborns. Delivering this information in concise, actionable formats ensures providers understand both the clinical and quality benefits, making outreach more effective and rewarding when improvements in health outcomes are observed. As an example of a provider incentive, we incorporated behavioral health (BH) measures into the provider's financial incentive structure. Although this occurs outside of the PIP, it still supports achieving the desired outcomes.

Identify strategy for continued improvement or overcoming identified barriers:
Each PIP is unique in its metrics, actions, target population, and supporting literature. Our overarching strategy is to conduct quarterly reviews and adjust based on performance data. These reviews evaluate deliverables, alignment with care recommendations, tools, population attributes, and cost implications to determine whether interventions should be maintained, modified, or replaced. Continuous learning drives this approach, with decisions guided by evidence and experience to optimize member health outcomes and improve overall PIP performance.

HSAG Assessment

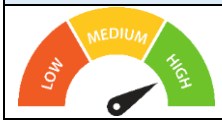
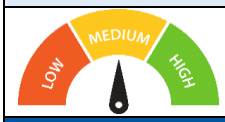


Table 12-2—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendation
HSAG recommended that ABH evaluate performance measures with rates below the NCQA national 50th percentile.
Response
Describe initiatives implemented based on recommendations: Provider Engagement and Education: Conducted training sessions on NCQA technical specifications for measures such as Controlling High Blood Pressure (CBP) and Blood Pressure Control for Patients with Diabetes (BPD), ensuring providers understand documentation and intervention requirements. Provider Plan of Action (POA) report for outreach and gap closure initiatives. These reports track provider-level interventions to improve HEDIS and Star measures. • Health Literacy and Member Outreach: Developed and distributed health literacy materials, including a Member Passport tool to guide members in preparing for provider visits. Posted HEDIS and Value-Added Benefits information on member and provider portals, newsletters, and mobile applications. Health campaigns from national as well as at the plan level were also implemented. • Practice Transformation Support: Deployed specialists to assist providers in scheduling members with gaps in care and improving adherence to preventive screenings and chronic condition management. • Community-Based Initiatives: Funded programs and partnerships to promote mental health and hypertension awareness. Aetna Clinic Day is positioned as a collaborative outreach event designed to close HEDIS gaps in care and improve compliance for various measures. The clinical partner helps determine the focus, often targeting immunizations and preventive screenings.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Key measures showing improvement include Controlling High Blood Pressure (CBP) and HbA1c control for diabetes, which met either the percentile benchmark or improvement goal.
Identify any barriers to implementing initiatives: Provider Engagement Challenges: Limited provider bandwidth and competing priorities impacted timely adoption of documentation and intervention practices. Data and Technical Specification Gaps: Ambiguity in measure definitions and coding requirements from NCQA and state sources delayed implementation. Member-Level Barriers: Social determinants of health (transportation, health literacy) and reduced funding for programs like tobacco cessation created obstacles to achieving benchmarks.
Identify strategy for continued improvement or overcoming identified barriers: Enhanced Provider Support: Continue offering targeted training and technical assistance, including simplified documentation guides and real-time feedback on measure performance. Data Integration and Analytics: Leverage predictive analytics and ADT data for rapid identification of members needing follow-up care, as piloted in the Readmission Risk Reduction Campaign. Member Engagement Expansion: Scale health literacy campaigns and community partnerships to address behavioral health and chronic condition gaps. Barrier Mitigation: Collaborate with state agencies to clarify technical specifications, advocate for funding restoration for cessation programs, and explore alternative transportation and telehealth solutions to reduce access barriers.

HSAG Assessment

Recommendation
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 recommended that the MCOs 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 the MCOs.
Response
Describe initiatives implemented based on recommendations: • Access to quality telehealth services for timely appointments. Currently, ABHLA has over 1200 individual behavioral health practitioners, across all regions of the state, who offer telehealth services. In addition to education provided through our quality monitoring and provider network monitoring programs, we offer telehealth best practice training with free CEUs/CMEs to providers through our vendor TPN.health. • Embedded CMs/PSSs at 8 behavioral health facilities, with plans to expand to additional substance use disorder facilities in late 2025/early 2026 • Member Incentive for completing a follow-up appointment after a FUH or FUM discharge • Pay-for-Quality value-based contracts for FUH, FUM, FUA • Patient-Centered Medical Home and Shared Savings contracts • CM live outreach for FUH • In August 2025, ABHLA implemented a Behavioral Health Transition of Care line and email box, which provides real-time assistance to hospitals to identify behavioral health aftercare providers who can deliver follow up care within at least 10 days of discharge from an ED or inpatient unit. We have educated providers about this service through the Louisiana Hospital Association conference, the ABHLA Provider Advisory Committee, and our provider website. In addition, ABHLA is actively recruiting behavioral health aftercare providers who can provide the needed follow up care with the required timeframes. • Thru mid-year 2025; a text campaign to members discharged for FUM or FUA were sent messages within 7 days to follow-up as well as information, like member services, to help them make appointments • IVR to members discharged for FUH; reminding them to follow-up with their provider as well as the ability to be connected to Member Services to help find and or make an appointment • Our Guardian Angel Program, which outreaches and engages members with ED visits related to opioid overdose or substance use disorder, launched in November 2025. Areas of priority for this program include ensuring members have timely follow up appointments and increasing member access to MAT, Narcan, and other recovery support as needed. • ABHLA is currently in the process of developing a Population Health Management Program with Mindoula that will focus on targeted outreach and engagement of our FUM/FUH population, to

increase the rate of follow up and ongoing behavioral health care. The targeted implementation date is late 2025/early 2026.

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

- Data analysis of previous text and IVR member campaigns show metric improvement and shows more improvement if we use multiple delivery methods. This helps us focus on the right methods for the right recipient.

The FUM/FUA text campaign showed great improvement and kept overall performance at a steady level, i.e., it continued performing at heightened levels

Identify any barriers to implementing initiatives:

- Telehealth provider/vendor OneTelemed no longer available for live outreach for FU measures
- Correct contact information for members when doing outreach

Identify strategy for continued improvement or overcoming identified barriers:

- Partnership with new vendor to assist in closing gaps
- Better alignment of campaigns to members to achieve maximum benefit by continuing to review campaign success rate as related to metric outcomes

HSAG Assessment

Recommendation

To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommended that the MCOs work with providers to improve post-discharge planning and care coordination.

Response

Describe initiatives implemented based on recommendations:

The RAP 2.0 program seeks to address all cause readmissions reductions by 2 percentage points YoY, aiming for ≤10% statewide average. Highlights of program:

- Risk stratification using RAP RiskScore (≥50% triggers intensive follow-up).
- ABHLA has (6) embedded staff members who (in combination with the UM team) work directly with members, hospital discharge planners, and providers.
- Weekly member follow-ups for up to 30 days post-discharge or sooner pending member's individualized needs.
- Channels: Telehealth, Multichannel outreach (SMS, IVR, telehealth, HealthHUB, MinuteClinic).
- Coordination with PCPs and specialists for follow-up appointments.
- Provider notification for high-risk members based on RAP RiskScore.
- Clinical team holds weekly integrated rounds to review drivers and solve for care gaps of top utilizers

- February 2025, ABHLA began covering short-term medical respite care to members discharged from acute care and identified as having housing insecurity with skilled care needs. These efforts support the recovery process through providing wraparound services and onsite nursing.
- Readmission Risk Reduction Campaign (NBA v4) launch on 6/20/2025
  - Scope: Outreach to ~6,600 members annually across TANF, CHIP, ABD, and Expansion populations.
  - Tactics: Personalized messaging, predictive analytics, and provider engagement to close gaps in care
- Transitions of Care (TOC) planning
  - 10/14/25 NBA campaign launch of Transitional Care Education Discharge + Observation Stays (MCD)

- intended to help reduce the risk of hospital readmissions among members who have been recently discharged from an ED visit or observation stay by prompting them to go to their follow-up visit and take medications as prescribed. This is the first Medicaid NBA to utilize the Admissions, Discharge, and Transfer (ADT) data source, allowing us to target members more quickly following discharge of their ED or observation stay.
  - Medication reconciliation.
  - Condition-specific assessments.
  - Coordination with PCPs and social supports to address non-medical drivers of readmission.
- Behavioral Health & SUD Initiatives

In addition to the initiatives listed for FUM/FUH/FUA (most of which will also address readmission rates):

- ABHLA has implemented several strategies to decrease substance use disorder readmissions:
  - Provider education about MAT through our vendor TPN.health, including:
    - Medicated Assisted Treatment for OUD (MOUD): Breaking the Cycle;
    - Starting Where The Client Is: Guidelines for Harm Reduction Practice with People who use Drugs;
    - Understanding and Treating High-Functioning Clients with Dual Diagnosis: Effective Integration of Therapeutic Approaches and Self-Help Programs (includes SBIRT training);
    - Substance Use & Pregnancy: Effects & Treatment
  - Provider bulletins about the LaSOR Opioid Response program and LA Bridge Program
  - Our embedded Peer Support Specialist program, which provides peer recovery support both during and after residential substance use treatment.
- Targeted outreach for members with new SMI/SUD diagnoses to connect them with behavioral health resources via SMS and Aetna Health member portal
- To reduce behavioral health readmissions, ABHLA is currently implementing an enhanced behavioral health high utilizer program that includes an increased focus on member linkage to primary care, peer support. and specialized behavioral health services such as ACT and IOP, an updated high utilizer dashboard, and a more focused interdisciplinary rounds process.
- CM live outreach for FUH
- Louisiana Maternal Overdose Mortality (MOM) Program: Project M.O.M. (Maternal Overdose Mortality) | Louisiana Department of Health
- SUD NBA Campaign
- Pay-for-Quality value-based contracts for PCR
- ATLAS/Shatterproof: Addiction Treatment Locator
- Patient-Centered Medical Home and Shared Savings contracts

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

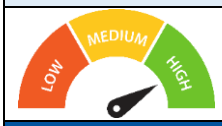
Noted downward trend in readmission rates from September 2023 forward.

Identify any barriers to implementing initiatives:

- Missing member information such as cell phone numbers, email address, no landline, etc.
- Member and member caregiver engagement

Identify strategy for continued improvement or overcoming identified barriers:

- Continued collection and update of member information
- Collaboration with state partner on future enrollment file updates

HSAG Assessment

Recommendation
To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommended that the MCOs focus their efforts on decreasing unnecessary imaging for low back pain. HSAG also recommended that the MCOs work with providers to trial solutions to reduce the inappropriate ordering of imaging studies.
Response
Describe initiatives implemented based on recommendations: Provider education: o Provider facing website directs providers to clinical practice guidelines (CPG) and bulletins for topics including lower back pain. o The QMOC adopted a CPG specific to the noninvasive treatment for acute and chronic low back pain. This CPG cites, "...there is no agreement on clear methods to define the source of low back pain, as symptoms and imaging findings are rarely determinative." o Provider toolkits and best-practice tips to meet compliance (Use of Imaging Studies for Low Back Pain (LBP)) o ABH uses EviCore for prior authorizations and review of imaging requests. They apply evidence-based clinical criteria aligned with the *Choosing Wisely* campaign to reduce unnecessary imaging. These guidelines are available to providers. EviCore guidelines EviCore guidelines align with *Choosing Wisely* principles by recommending against imaging for most low back pain within the first six weeks unless "red flags" are present. They emphasize that advanced imaging like MRI or CT is considered only after a face-to-face clinical evaluation and failure of a provider-directed conservative treatment plan (typically a six-week trial). Imaging is approved for red flags such as neurological deficits, signs of infection, tumors, or trauma. • Imaging is often unnecessary as most back pain resolves on its own within this timeframe. • Clinical evaluation is mandatory first: An in-person evaluation by a physician is required before any advanced imaging. • X-rays are often required first: Plain X-rays must be reviewed before considering advanced imaging for musculoskeletal conditions. • Failure of treatment is a key factor: Approval for advanced imaging is contingent on demonstrating that a period of conservative treatment has failed to produce clinical improvement. A six-week trial of provider-directed conservative treatment, like physical therapy, is typically required before advanced imaging is considered. • Conservative treatment is promoted: EviCore promotes conservative care, noting that early imaging can lead to higher costs and potential for unnecessary procedures.
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: N/A

HSAG Assessment

Recommendation
To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommended that the MCOs work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females.
Response
Describe initiatives implemented based on recommendations: Annually, providers are educated on the appropriate age range (21-64 years) for cervical cancer screenings based on HEDIS tech specs.
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: Annual education will highlight the appropriate age range for cervical cancer screenings and be updated to include identifying information on how to identify a non-recommended cervical cancer screening.
HSAG Assessment


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

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

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

Recommendation
HSAG recommended 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).
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):
Identify any barriers to implementing initiatives:
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

Recommendation
HSAG recommended 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.
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. Currently ABHLA submits a quarterly data file to LDH of network providers who should be showing in the online directory. LDH provides the file to the auditors who then randomly select 125 providers to audit. The audit findings are then sent back to ABHLA for verification. The Provider Experience team evaluates the data and makes outreach to providers to obtain correct demographic information. If the provider agrees that ABHLA had the correct data and in auditor was incorrect, the provider will submit a signed attestation back to ABHLA. If the provider agrees with the auditor, ABHLA will make the appropriate corrections to the data and the online provider directory will be updated.
Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Identify any barriers to implementing initiatives:
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

Recommendation
HSAG recommended 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.
Response
Describe initiatives implemented based on recommendations: Network providers can contact the ABHLA call center 24/7 to check a member's eligibility. They can also visit the LDH site (MEVS) to verify eligibility if they prefer to do it online. There have not been any barriers to member's care in this process.

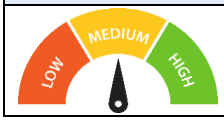
Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Identify any barriers to implementing initiatives:
Identify strategy for continued improvement or overcoming identified barriers:
HSAG Assessment


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

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

Table 12-6—Follow-Up on Prior Year's Recommendations for CAHPS

Recommendation
HSAG recommended 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.
Response
Describe initiatives implemented based on recommendations: • Development of Health Literacy materials and understanding of Value-Added Benefits, Post HEDIS and Value-Added Benefits information to the member and provider sites as applicable, and Availity • Member Services Director trained staff on talking points about Louisiana Value Added Benefits and scheduling screenings • Post Health literacy information in Member newsletters and on Member website under resources • Created member Passport, a document that guides members to take important information, compile a list of questions and concerns for their provider, list of medications, etc encouraging members to talk to their provider. This is posted on the member website as well as links through the mobile application. • Increased Provider and Member Newsletter articles about obtaining care, getting help from customer services, and scheduling screenings. • Practice Transformation Specialist working with providers on scheduling members with gaps in care • ABHLA funded community efforts for: Sista Midwife, American Diabetes Association and National Medical Association Mental health/Hypertension Awareness • Quarterly review of Geo Access for Urban and Rural • Wellness and Prevention Mailers: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and EPSDT aging out, Maternity Matters (incentive program for prenatal visit, postpartum screening, dental visits and childcare support

- Outreach Campaigns: Healthy Kids, Healthy Pregnancies, Healthy Babies, EPSDT, Obesity, foster children, and Well Child Visits. Upcoming: Immunizations and Vaccine, provider learning series on benefits of breastfeeding, weight management programs

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

- Met with providers through the Provider Advisory Committee (PAC) on CAHPS results and discussed ways of improving care
- Created additional Health Literacy documentation for members
- Redesigned member webpage describing Value-Added Benefits, so they are easier to understand
- Bi-weekly meetings with ABHLA's mPulse (messaging system) representative to review campaigns, frequency, penetration and time limits to ensure members are getting information about needed health screenings and preventative treatment.

Identify any barriers to implementing initiatives:

Provider

- Provider shortages: Many areas, especially rural parishes, suffer from a lack of primary care providers and specialists. This leads to long waiting times and fewer available appointments.
- Scope-of-practice restrictions: Louisiana has historically imposed limits on nurse practitioners and other non-physician providers, reducing their ability to help fill care gaps. Efforts to modernize these laws are ongoing.

Geographic and Transportation Challenges

- Rural isolation: Residents in remote areas often live far from clinics or hospitals. Limited public transportation options make it difficult to attend appointments.
- Infrastructure limitations: Poor Road conditions and lack of transit services further complicate travel to healthcare facilities.

Social and Cultural Factors

- Health literacy: Limited understanding of when and how to seek care can prevent timely appointments.
- Language and cultural barriers: Non-English speakers or those from marginalized communities may struggle to navigate the healthcare system.

Scheduling and Availability

- Limited appointment slots: Clinics often have restricted hours or are overwhelmed, especially in underserved areas.
- Long wait times: Patients may wait weeks or months for routine or specialist appointments due to high demand and low provider supply.

Provider Panels Challenges and Barriers:

  - Access Gaps: In rural areas, limited provider participation in panels can lead to long travel times and appointment delays.
  - Panel Closures: Some providers may close their panels to new patients due to capacity or reimbursement concerns.

Identify strategy for continued improvement or overcoming identified barriers:

Aetna Better Health of Louisiana continues to identify opportunities for improvement and identify root causes of dissatisfaction and barriers to improvement to develop action planning and activities to drive service improvements. Feedback from:

1) Member Advisory Committee (MAC),
2) Provider Advisory Committee (PAC), and

3) Committee for Service Improvement (CSI)

ABHLA has a monthly workgroup to address members and provider experience, essentially addressing areas of improvement per the CAHPS results. The group's main focus:

1) Ensure that members are getting their screenings and seeing their providers,
2) have the materials to enhance their health literacy and in turn know what value-added benefits are available for their best care, and
3) provider coordination of care and resources to aid in screening of patients as listed in #1 above.

Participants include:

1) Medical Director, Chief Financial Officer,
2) Director of Grievance and Appeals,
3) Director of Utilization Management,
4) Director of Provider Relations,
5) Director of Network and Contracting,
6) Directors from Case Management, both Physical and Behavioral Health,
7) Lead Director of Quality,

ABHLA Quality staff including HEDIS, Behavioral health, Social Determinants of Health (SDoH), Accreditation, Champaign Project Managers, Director of Member Services, Director of Community Outreach, Director of Health Equity, and Senior Manager of Business Consulting.

HSAG Assessment

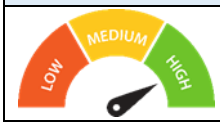


Table 12-7—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey

Recommendation
HSAG recommended that ABH focus on increasing response rates to the Behavioral Health Member Satisfaction Survey for its adult and child populations.
Response
Describe initiatives implemented based on recommendations: -member services queue messaging heard about survey when member calls in -all staff mandatory member experience training to increase knowledge, promote survey, and respond to members in an empathetic way -send mPulse SMS notification/reminder about upcoming survey
Identify any noted performance improvement as a result of initiatives implemented (if applicable): -TBD after 2025 survey results
Identify any barriers to implementing initiatives: -accurate member contact information -ABHLA does not administer this survey -ABHLA needs to be notified of the timeframe for administration so as to make sure any member notification can be supported

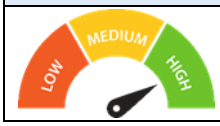
Identify strategy for continued improvement or overcoming identified barriers: -continue working with the Member and Provider experience workgroup on strategies to ensure correct member information (i.e., address, phone number, assigned providers) -Notify members about upcoming survey at corresponding quarterly Member Advisory Committee (MAC) meeting and community events
HSAG Assessment


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

Recommendation
None identified.

Table 12-9—Follow-Up on Prior Year's Recommendations for QRS

Recommendation
The MCEs were directed to reference the recommendations made for PMV and CAHPS as the Health Plan Report Card reflects HEDIS and CAHPS results. HSAG did not make additional recommendations specific to the QRS activity.

Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from ABH's HEP submission from July 2025.

Health Equity Plan

HSAG reviewed ABH's HEP[18] submitted July 2025. 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.

[18] 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 2025: Implement a targeted initiative in an underserved community by Q4 2025
ABHLA aims to enhance access to primary care for underserved communities, ensuring quality healthcare is available to all, regardless of socioeconomic status. The organization focuses on addressing disparities by considering race, ethnicity, language, and cultural competence. They gather feedback to improve services and offer language translation to eliminate barriers to care. Their commitment to quality and minimizing disparities is central to their mission of providing exceptional care for every member. We have identified two specific, measurable goals to concentrate on: achieving a 2% year-over-year increase in primary care provider visits among LatinX members over the next three years and having ABHLA lead quarterly Joint Oversight Committee (JOC) meetings with our primary care groups in key communities each year. In relation to increasing PCP visits among LatinX members, the HEDIS measure, *AAP-Adults Access to Preventative/Ambulatory Health Services*, offers valuable insights into overall healthcare access. We are monitoring this measure using an existing dashboard that tracks quality performance by race and ethnicity according to HEDIS standards. AAP provides a detailed overview of how we are facilitating access to essential health services for LatinX members. As of our most recent data for 2025 (up to March 2025), the rate for LatinX members stands at 49.58%. There is still significant progress to be made in the upcoming months. For reference, the AAP rate for LatinX members was 71.66% in 2023 and 77.20% in 2024. Based on our overall objective, we expect our 2025 rate to reach at least 78.74% or higher. To enhance accessibility and engagement, we are implementing strategic initiatives focused on LatinX communities. We plan to expand community outreach to ensure culturally relevant healthcare information is available. Additionally, we will partner with local organizations to host health fairs and wellness workshops, fostering a focus on preventative care. Collaborating with the Trusted Provider Network (TPN), we aim to provide training in cultural competence and language skills, ensuring our members feel understood and respected in healthcare settings. Tracking attendance data for community events is a priority, as it will help us improve inclusivity and representation. We are also developing an implementation plan to collect demographic data respectfully for impact reports. By partnering with community leaders, we aim to understand the unique needs of the LatinX community and reduce barriers to care. Ultimately, this will lead to increased visits to primary care providers, promoting better health outcomes and equity in healthcare. Every quarter, we hold Joint Operating Committee (JOC) meetings with primary care provider groups to discuss data trends, challenges, and strategies aimed at enhancing health equity and outcomes. Since January, we've hosted 19 meetings with nearly 150 participants, ensuring diverse representation. These sessions are actionable,

focusing on clear goals and follow-up plans, leading to improved communication, workflow efficiencies, and member experiences. We address value-based payments, social determinants of health, claims issues, and member grievances, facilitating a two-way information exchange. Each meeting is customized to meet the group's needs, allowing providers to share insights and navigate healthcare complexities effectively. Our Health Equity & SDoH team is implementing a targeted initiative called a "Health Ambassadors Program" specifically designed for the LatinX community. This program will involve recruiting and training local community members as health ambassadors who are bilingual and culturally competent. These ambassadors will serve as liaisons between the community and healthcare providers, helping to bridge gaps in communication and understanding. The identified partner we are launching this initiative with is LA Voz Nola. LA Voz works to improve the quality of life in the Latino communities of Louisiana by providing a centralized location for the Latino community to find resources pertaining to, highway & occupant safety, parenting, community development, k-12 programs, prevention education, advocacy etc. By working closely with LA VOZ, our strategic framework to implement strategies that improve access to care includes: • **Community Engagement and Outreach:** Ambassadors would organize regular health workshops and seminars in community centers, schools, and churches. These events would cover topics such as preventive care, nutrition, mental health, and chronic disease management, all tailored to the cultural context of the LatinX community. • **Personalized Support and Navigation:** Ambassadors would assist community members in navigating the healthcare system, helping them understand their healthcare options, schedule appointments, and follow up on care plans. This personalized support would aim to reduce the intimidation and complexity often associated with accessing healthcare services. • **Feedback and Improvement:** Health ambassadors would gather feedback from participants about their experiences and challenges in accessing care. This information would be crucial for ABHLA to continuously adapt and improve its services, ensuring they remain responsive to the community's needs. • **Collaboration with Local Organizations:** The program would partner with local schools, non-profits, and faith-based organizations to maximize reach and impact. These collaborations would leverage existing trust within the community and ensure that initiatives are well-received and effective. By implementing the Health Ambassadors Program, ABHLA would not only enhance access to primary care for the LatinX community but also foster a sense of empowerment and ownership over their healthcare decisions, contributing to improved health outcomes and reduced disparities. Our goal is to have this program launched by December 2025.
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 • 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: • Achieve 2% improvement in diabetes management among ABH LA members for priority populations

Milestones to be Completed by December 2025: Expand program reach and achieve 2% improvement in diabetes management among priority populations
Chronic disease management is yet another area where we concentrate on tackling disparities and advancing health equity. Our primary objective is to diminish health disparities in chronic disease outcomes, specifically focusing on diabetes and hypertension within underserved and vulnerable populations. Members who have these chronic conditions are identified via a variety of ways, such as claims data & HEDIS care gaps reports. Activities and services are structured to support enrollees with multiple chronic condition to achieve their highest degree of self-management. Enrollees with chronic conditions receive the following to assist with education and encouragement to seek care and retention to care through the below interventions to provide a comprehensive experience throughout the continuum of care. In 2024, ABHLA reported out on several interventions set in place to combat diabetes and hypertension management among Black, White, and rural member populations. These programs continue to lead the way in improving the well-being of our communities. A recap of these continuous programs are as follows: • **GA Foods Meal Subscription Boxes**: ABHLA, in partnership with GA Foods, has launched a culturally sensitive nutritional intervention to address food insecurities for individuals with chronic conditions. The program educates members on healthier food choices and provides nutritious, medically suitable meals, including various dietary options. Eligible adults must not comply with CBP and HBD HEDIS measures and are identified through enrollee files and claims data. Participants can join quarterly and receive two meals per day for 14 days, totaling 28 meals each quarter. • **Signify Health/Healthy Home visits**: ABHLA's Healthy Home Visit (HHV) program offers a unique perspective on member care through annual visits by a licensed NP or Physician to members' homes. This service complements, rather than replaces, the relationship with the member's primary care provider (PCP) and aims to provide a comprehensive view of their health status. Participation is voluntary and does not affect coverage. The program, facilitated by Signify Health, includes an introductory letter and a follow-up call to schedule visits. Clinicians assess both medical and non-medical factors, gathering information on safety, nutrition, and social determinants of health. • **Health Coach interaction**: Health Coaching is also a major component of disease management. Our RN Health Coach reviews data and identifies members who are not currently in care management and begins her outreach to opt members into healthy coaching. 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. • **Detailed provider reporting**: Ensuring our provider partners are equipped with valuable tools that enhance patient care and improve outcomes is crucial for us. As previously mentioned, the "ED_Diversion_PCP" report is our most active and up-to-date resource for optimization. This report highlights various diagnoses, such as diabetes and hypertension, to emphasize disparities in blood pressure and diabetes management. Our Health Equity and Quality teams will continue to monitor the data closely to swiftly address any identified disparities. For 2025, Our goal is to continue our existing programs and to continue improving diabetes rates by building on the successes and lessons learned from previous years. We plan to introduce new, innovative interventions that further address the needs of our members while enhancing the effectiveness of our current strategies. In 2024, our final rate for the HBD measure was 47.82%, our goal for 2025 is to meet 45.82% which is a 2% improvement from the previous year. (inverted HEDIS measure; lower rates indicate better performance) As of our most recent data for 2025 (up to March 2025), our rate is at 20.80%. HEDIS rates are calculated continuously throughout the year. As we know, the final rates will not be available until after December. However, we are working with our internal provider facing teams to work with our provider groups to lower this rate and work towards meeting our 2% YoY rate.

Our ultimate mission is to empower our members to lead healthier and happier lives, and we are dedicated to making that a reality. To achieve this, we are implementing a multifaceted approach that emphasizes collaboration, education, and support internally and externally. One of our notable external collaborations is with the American Diabetes Association. ABHLA is a partner that provides funding and support for local programs, research, juvenile Diabetes summer camp, insulin affordability and more. We are currently developing an implementation plan for a new initiative titled "Pathways to Wellness." This program is designed to enhance diabetes management and education for members residing in underserved, high-disparity areas, with a particular emphasis on rural, Black, and economically vulnerable communities. Ideally, this initiative will include: • An educational series conducted in designated community centers, churches, schools, and similar venues. Topics covering budget-friendly nutrition, insulin usage, medication adherence, and exercise in resource-limited settings. • Information on accessing the ADA's insulin affordability programs and manufacturer discounts. • Member Services/Navigation support for ABHLA members from care coordination teams. It is our hope that this program will contribute to our goals of improving HBD rates.
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 2025: Create a Health Equity focused community initiative based on outcomes of year 2024 assessment
ABHLA is dedicated to engaging with our community-based organizations and members. Through these collaborations, we provide an extensive array of services and programs tailored to meet the unique needs of our diverse membership. By nurturing a spirit of community and cooperation, we cultivate a supportive atmosphere where individuals can flourish and effect positive changes in their health and well-being. ABHLA has organized multiple meetings and events to unite our partners and members for discussions on key issues and resource sharing. We conduct quarterly Enrollee Advisory Council meetings aimed at engaging with our community members and enrollees. These gatherings facilitate meaningful conversations surrounding concepts, program initiatives, identifying barriers, and exploring solutions from the members' viewpoint. It is essential for us to honor the perspectives of all council enrollees. To date, we have held 1 meeting this year with the anticipation of 3 more by December 2025. As highlighted in our milestones from 2024, we conduct assessments of our community roundtable or EAC events with detailed input from stakeholders by collecting their feedback and analyzing their experiences. Our strategy involves building strong partnerships with local organizations, continuously engaging with our members to gather valuable insights, and implementing innovative solutions that enhance healthcare accessibility. We emphasize the importance of inclusivity, ensuring that our programs are designed to cater to the diverse backgrounds and needs of our community members. Through ongoing dialogue

and feedback, we refine our initiatives to maximize their impact, driving meaningful and sustainable change. This ensures that our strategies and programs are not only responsive but also effective in addressing the real-world challenges faced by our members. By fostering an environment of open dialogue and active participation, we empower our community to voice their concerns and suggest actionable improvements. This feedback loop is crucial in refining our approach and enhancing the impact of our initiatives. We are proud to work alongside community leaders and stakeholders who share our vision of a healthier, more connected community.

In addition to our EAC meetings, we organize a diverse range of community events, engaging representatives from all nine regions. Since January, our Community Development team has actively implemented our strategy on the ground. We host and participate in numerous initiatives, including resource fairs, food distributions, and regional health and wellness events. Q1, we had 77 events, provided $149,500 in sponsorships, and provided 620 health screenings. Q2-Q4 data is currently in progress, once this final tally becomes available, we will update our records to reflect our quarterly performance. Our community outreach efforts have been instrumental in fostering connections and providing vital resources throughout our member regions. Q1 efforts at a glance with completed funding include, $10K GOODR & ABHLA 318 Field Day Grocery Giveaway, $5K Nola Culture Aid Food Distribution, $10K The Wall Project (Sow Good Seeds Community Gardens), $7.5K American Diabetes Association partnership, These events not only help address immediate community needs but also promote long-term health and well-being through education and resource distribution.

As highlighted in our 2024 year-end report, we have successfully launched the first-of-its-kind Community Resource Center (CRC) in collaboration with CVS's latest Workforce Innovation and Talent Center (WITC) in Baton Rouge. The CRC serves as a centralized hub, offering individuals access to a diverse array of services and resources tailored to their specific needs. Through our partnership with CVS, we have established an environment that promotes not only health and wellness but also workforce development and educational opportunities. The center provides various programs, including health screenings, educational workshops, and job training sessions, all designed to empower community members to take charge of their health and career trajectories. Since we first opened our doors, we have provided a variety of programs including fitness classes, cooking demonstrations centered on healthy eating, volunteer income tax assistance, health advisory meetings, homebuying courses, and DCFS classes, among other events. Our objective is to dismantle the barriers that often hinder individuals from accessing essential care and support. By consolidating comprehensive services in a single, convenient location, we aspire to create a lasting impact on the lives of those we serve. According to our attendance logs, we have served over 500 individuals since it's inception. Our data collection process at the Community Resource Center (CRC) primarily gathers information from all community members, without distinguishing Aetna members specifically. Through our collaboration with CVS and the Workforce Innovation and Talent Center (WITC), we continue to promote health, wellness, and workforce development, ensuring that each individual has the opportunity to thrive.

Based on the outcomes of 2024, Our 2025 milestone is to create a Health Equity focused community initiative based on previous year outcomes. The community based initiative we would like to implement by December 2025 is to launch a Resource Navigator Pilot at the CRC. Use existing CRC staff, launch a pilot navigator program that:

- Collects SDoH data tied to health outcomes and links individuals to care based on their conditions and zip code-specific services
- Identifies ABHLA members by using voluntary sign-in sheets

The outcome of this pilot program will help with identifying and referring Aetna members more effectively and improve engagement from community and ABHLA members.

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 2025: Evaluate and expand pilot initiative to all 9 regions by December 2025
Maternal and child health is a key priority for ABHLA. We are committed to making a substantial impact in this area by implementing comprehensive programs and partnerships that address the diverse needs of our member communities. Our focus is on fostering environments where expecting mothers and their families receive the support and resources they need to thrive. By leveraging innovative solutions and community-driven initiatives, we aim to improve health outcomes and ensure that every family has access to high-quality care during the critical periods of pregnancy and childbirth. During this time, we have established a contractual partnership with Sista Midwife Productions. This sponsorship will provide educational opportunities for up to 50 birth workers from May to December 2025. The education will encompass training, support, coaching, and business development tailored for birth workers in Louisiana. Our goal is to foster a more diverse workforce of doulas and perinatal community health workers to help reduce burnout and enhance their impact. Throughout the contract period, Sista Midwives will support birth workers through: In-person continuing education and skill-building sessions, Virtual continuing education, Professional leadership development calls and Group and individual business development coaching. Our objective is to continuously collaborate with LDH to persist in identifying Doula organizations that are included in the state-approved doula registry. By doing so, we will enhance our network of trusted professionals available to support our members during pregnancy and childbirth. This collaboration will allow us to streamline services and ensure that expecting families have access to well-trained, compassionate doulas who can provide critical support during these pivotal moments. Alongside our in-person Doula services, ABHLA now offers virtual support for our members through the vendor, Pacify. Pacify is an evidence-based telehealth mobile application and perinatal solution that provides 24/7 access to a national network of International Board Certified Lactation Consultants (IBCLC) and Doulas via live video consultations. From January to April 2025, we recorded 319 enrollments. The most recent enrollment data by race shows the following distribution: 1% Asian, 43% Black, 15% Not Disclosed, 1% Native Hawaiian/Pacific Islander, and 40% White. This data indicates that our Black and White populations are utilizing this service more frequently than others. While we aim to enhance our in-person doula services across all regions we serve, we currently depend on Pacify as an alternative to ensure our members receive the needed support and care due to the shortage of doulas. We are actively engaging in ongoing discussions with various organizations to explore collaboration and improve doula support. We're focused on boosting father involvement and mentoring young men during the prenatal and postpartum stages. We've teamed up with Fathers on a Mission (F.O.A.M.), a community-based group that helps men become positive father figures by connecting them with job opportunities, resources, and relationship-building activities. In 2024, F.O.A.M. took part in ABHLA-sponsored baby showers and seminars, attracting 312 attendees in Region 2. We aim to strengthen this partnership in 2025 by planning meetings and classes for ABHLA members and

families, expanding to all nine regions. We're also launching a virtual fatherhood training program to provide resources and support for fathers facing geographical or time constraints. This initiative will include a live webinar on fatherhood challenges and opportunities during the prenatal and postpartum periods. The goal is to create a community among fathers and equip them with tools for effective communication, mental health awareness, and co-parenting strategies, ultimately building stronger families.

In addition to doula support, fatherhood programs & our pacify virtual platform, we are currently monitoring three key measures: Prenatal and Postpartum Care (PPC), Preterm Birth (PTB), and Low Birthweight (LBW), with the objective of achieving either the 50th percentile or a year-over-year improvement of 2%.
Based on our Aetnalytics reporting, we are pending final rate calculation for these measures (PPC, PTB, LBW) through 2024.
To effectively improve our PPC rates, we will adopt the following strategies:

- Identify groups with the lowest postpartum care rates and evaluate barriers such as access, awareness, and scheduling difficulties.
- Establish a feedback loop with members to gather insights about their postpartum experiences. This will help pinpoint areas for improvement and refine our services to better cater to new mothers' needs, ensuring our strategies are in harmony with their realities.
- Enhance data collection and analysis to track our progress and assess the impact of our interventions. We will consistently monitor postpartum care rates and identify demographics that may require additional support.

For PTB and LBW, we plan to introduce targeted initiatives addressing the root causes of these issues. This involves a comprehensive approach focusing on medical and socio-environmental factors affecting maternal and neonatal health, including:

- Enhancing access to prenatal care by partnering with local organizations to create mobile clinics for expectant mothers in underserved areas.
- Organizing nutrition and wellness workshops for expectant mothers and collaborating with partners to provide prenatal vitamins and nutritious food.
- Working with community organizations and local leaders to offer peer support and mentorship for pregnant women, addressing socio-environmental challenges and providing resources in multiple languages.
- Leveraging data analytics to analyze demographic trends and identify risk factors associated with low birth weight deliveries.

These initiatives aim to improve maternal and neonatal outcomes, reduce preterm birth rates, and decrease low birth weight deliveries by enhancing the overall health of our members.

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 2025:

Solidify partnerships with rural CBOs, and implement a targeted initiative to address specific BH needs by December 2025

Addressing mental health disparities in rural communities is a vital objective for us. We are convinced that by collaborating and concentrating our efforts on bridging community resource gaps, we can significantly enhance the overall well-being of individuals living in these areas. Mental health disparities are an urgent concern that requires attention, and we are committed to ensuring that everyone, regardless of their geographic location, has equal access to essential resources and support. By December 2025, we aim to achieve a key milestone: Solidify partnerships with rural CBOs and implement a targeted initiative to address specific BH needs.

We have made progress towards achieving this important milestone. At present, we have established a vendor partnership with Trusted Provider Network (TPN). Through their platform, we offer training sessions to all our in-network providers. 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. These trainings are 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 are offered live and on-demand throughout the tenure of ABH LA's relationship with TPN.health. For 2025, we anticipate offering 14 webinars/trainings, plus ODE. In addition to the upcoming live events, our provider network has access to our full on demand library.

Upcoming 2025 Webinars:

1. Perinatal Mental Health: Doulas Do It: Improving Perinatal Mental Health Through Sankofa: June 26th, 2025 11am-12:30pm EST
2. Combating Stigma: maternal health and SUD; signs/symptoms: peer to peer; referral resources
3. Tribal cultural competence
4. "Evidence-based practices, promising practices, emerging best practices"
5. Telehealth Practices
6. Integrating physical and behavioral health
7. Assessing and treating individuals with co-occurring I/DD
8. I/DD and dual diagnoses
9. Harm Reduction -extend 2023 webinar
10. MAT
11. Preventing/Reducing Exposure to ACEs (SHIP)
12. Reduce Barriers to BH Services (SHIP - State Health Improvement Plan)
13. PSS: Peer Support Specialists Services (SHIP) -(SHIP: training to increase our network of PSSs)
14. M-CHAT Training

2024 On Demand Education:

- ODE: The Value of Peers as Part of the Interdisciplinary Care Team
- ODE: Human Trafficking for Medical and Behavioral Health Providers | TPN.health
- ODE: Chronic Physical Health Conditions and Serious Mental Illness: | TPN.health
- ODE: Developing a Transgender-Culturally Fluent Praxis: | TPN.health
- ODE: A Fathers Presence: The Significant Impact Fathers Have on their Children's Well-Being | TPN.health
- ODE: Domestic Violence Dynamics: Trauma-Informed Screening with a Health Equity Focus | TPN.health
- ODE: Obesity and Mental Health in High Risk Communities | TPN.health
- ODE: Addressing Drivers of Inequities in Lactation Support | TPN.health
- ODE: Working with Patients Presenting with Suicidal Behaviors: | TPN.health
- ODE: Equity, Diversity, and Inclusion: Religion & Spirituality | TPN.health

We expect ongoing collaboration with TPN to provide further training opportunities that meet the educational needs of our providers annually.

Additionally, offering virtual support is a significant advantage for our ABHLA members. OneTelemed previously provided virtual behavioral health counseling and medication management sessions to ABHLA enrollees. During 2025 cross-departmental review and strategy, Mindoula was explored and deemed to be a better fit for ABHLA enrollees. Mindoula Clinical Services' Population Health Management Program (PHMP) is a precision solution that targets, engages, and serves enrollees with SMI and/or SUD and other comorbid medical conditions through team-based, tech-enabled, care extension services. This focused approach includes:

- Identification of enrollees for the PHMP
- Outreach and enrollment of enrollees using an intake process specific to SMI and SUD populations
- Provision of tech-enabled programmatic interventions that include content and methods tailored to reducing total costs of care by addressing behavioral, medical, and social needs specific to SMI and SUD populations.

These interventions are designed to enhance participants' skills, strategies, and supports, which in turn help to prevent and reduce unnecessary and avoidable medical costs associated with SMI and/or SUD and other comorbid medical conditions, during the program and even after its completion. This new behavioral health partner will help improve FUH and FUM 30 day HEDIS measures for ABHLA via virtual appointments to complete enrollment with screening. At this time, our go-live date with Mindoula is pending. We will be launching a go-live date in the coming months.

We also 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. CHC's are designed to identify health issues at a community level using key health data to identify ways to improve. Community Health Councils are created through an extensive process that may begin 4-6 months prior to the initial meeting of the Council. In 2024, four Community Health Councils were initiated, with the majority focused on transportation access based on the feedback and votes from the community-based organization representatives who expressed lived experience proves a great need for more solutions on this SDoH barrier. For 2025, the councils that have been initiated are in Assumption Parish, Calcasieu/Allen Parishes (joint council between 2 neighboring parishes with one meeting held) and newly established, Orleans Parish. These councils serve as crucial platforms for dialogue and action, enabling community members to voice their concerns, share insights, and collaborate on solutions tailored to their unique challenges.

Our goal is to provide continuous updates on the strides we are making to alleviate mental health disparities in rural communities that encompasses both immediate and long-term solutions. To achieve this, we are focusing on several key areas:

- Community Engagement: We are strengthening our partnerships with local organizations and leaders to better understand the unique challenges faced by rural communities. By working closely with these stakeholders, we can develop tailored interventions that address specific needs and promote mental health awareness.
- Training and Education: We are implementing comprehensive training programs for healthcare providers in rural areas, focusing on mental health first aid, cultural competence, and trauma-informed care. By equipping providers with the necessary skills and knowledge, we can improve the quality of care and support offered to our members.
- Resource Allocation: We are committed to allocating resources effectively to ensure that rural communities have access to essential mental health services. This includes funding community-based initiatives that promote resilience and well-being.
- Continuous Monitoring and Feedback: We are establishing robust mechanisms for monitoring the impact of our interventions and gathering feedback from community members. This will enable us to make data-driven decisions and adjust our strategies as needed to maximize their effectiveness.

Lastly, In 2024 we implemented school based mental and behavioral health telehealth projects providing counseling sessions to 83 students, as well as building activities to address childhood obesity. We created sensory rooms, efforts led by our community development team, partnered with Cajun Nation Seasoning company to educate three Evangeline parish schools on hypertension and healthy eating, as well as, identified a partner (VIA Link) to deliver free staff education on behavioral health school topics. For 2025, we are pausing our school based efforts due to leadership changes at the school we were in partnership with. We are currently strategizing and sourcing other schools who would be willing participants. Our hope is to have an update on this program in the coming months.

By December 2025, we aim to establish a community-led mental health workgroup hosted by ABHLA, dedicated to solidifying partnerships with rural Community-Based Organizations (CBOs) and addressing specific behavioral health needs. This program will enhance access to mental health services in rural areas by utilizing both in-person

and virtual resources. The initiative will kick off with the creation of a collaborative task force that includes representatives from rural CBOs, local health departments, mental health professionals, and community leaders. This task force will work together to pinpoint the most urgent behavioral health challenges faced by the community, such as substance use disorders, depression, and anxiety—issues that are often intensified by isolation and resource scarcity in rural environments. Once these needs are clearly defined, the task force can create targeted interventions, including mobile mental health clinics that serve underserved areas. These clinics will offer counseling services, medication management, and mental health screenings. Collaborating with local schools and community centers will help reach individuals from diverse demographics. Through these efforts, we are confident in our ability to make meaningful progress in addressing mental health disparities in rural communities. By fostering collaboration, leveraging technology, and empowering local providers, we aim to create a sustainable and supportive environment where everyone has the opportunity to achieve optimal mental health.
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 2025: Deploy a tailored intervention through collaboration with field teams and community-based organizations that address heart and mental health disparities by December 2025
Aetna Better Health recognizes that a diverse array of social, cultural, economic, and environmental factors significantly affect both individual and community health outcomes. In evaluating community health needs, the health plan considers key elements such as poverty, transportation availability, food access, and housing adequacy. By the end of 2024, our Community Cares team enhanced our Community Resource Directory (CRD), which now includes information on 20,000 organizations providing no or low-cost assistance related to social determinants of health. From January to June 2025, we added over 2,500 additional organizations to this essential resource directory. The CRD currently features more than 23,000 organizations, categorized by social risk, available for our members. Our ongoing efforts to enhance the Community Resource Database and streamline the referral process are designed to improve the overall efficiency and effectiveness of our support systems. By continuously updating and expanding the CRD, we aim to provide a comprehensive directory of resources that cater to the diverse needs of our member population. The member portal is now fully functional, allowing members to self-refer through the app or portal. They can also save resources and assess the capacity of organizations to obtain the required assistance. We are actively monitoring closed-loop referrals and have made updates to the dashboard to improve reporting for case management teams. These enhancements enable better

identification of members with open referrals that have been pending for less than 30 days, as well as those pending for more than 30 and 60 days.

In addition to the CRD, the Member REACH team is proactively engaging in outreach initiatives throughout LA to tackle social risks. They connect with members who are not enrolled in case management to evaluate their social determinants of health (SDoH) needs and to offer vital resources. Additionally, the REACH team identifies existing resource gaps, while the Community Cares team, working directly in the community, strives to address these shortcomings. By adopting a proactive stance, Aetna Better Health is committed to bridging the divide between members and essential resources, ensuring that everyone has the chance to lead a healthy and fulfilling life. As of Q1 2025, there were 29,611 total calls performed, 345 screening performed and 970 referrals provided. There were also 555 inbound calls received, 3 average referrals per member and 157 members were able to be transferred to our care management teams. The top referral categories were food (37.94%), financial assistance (24.85%), housing (19.90%) and education/employment (12.06%). Through these initiatives, Aetna Better Health continues to demonstrate a steadfast commitment to addressing the intricate web of social determinants that impact health outcomes.

As mentioned in previous reports, we have established Community Health Councils (CHCs) that focus on social risk data within their respective areas, collaborating with local organizations to mitigate social risks and address the needs of both members and the wider community. For 2025, the councils that have been initiated are in Assumption Parish, Calcasieu/Allen Parishes (joint council between 2 neighboring parishes with one meeting held) and newly established, Orleans Parish. These councils serve as crucial platforms for dialogue and action, enabling community members to voice their concerns, share insights, and collaborate on solutions tailored to their unique challenges. By leveraging local expertise and strengthening community ties, the CHCs are instrumental in advancing our mission to address social determinants of health effectively.

ABHLA takes pride in working closely with our provider partners to educate and increase awareness of SDoH needs our members face. Through collaborative efforts, we aim to empower providers with the knowledge and tools necessary to identify and address these needs effectively. The impact of the provider SDoH Incentive with ongoing initiatives includes:

- Integrating SDoH data with clinical outcomes to identify cohorts, aligning with HEDIS/VBS contracts for better provider incentives.
- Power BI Dashboard completed, covering all enrollee SDoH touchpoints to align with HEDIS metrics and address care gaps.
- Monthly Provider SDoH Incentive Data: Tailored analysis shared with provider POCs, categorized by demographics and needs.
    - Offers trending insights for regional needs, aiding strategic investments and collaboration.
- Developed a Provider Tip Sheet for staff and provider discussions, promoting a holistic enrollee care approach.
- Created a Provider Care Management Referral Form for referring members with multiple SDoH needs.

Lastly, our milestone for 2025 is to Deploy a tailored intervention through collaboration with field teams and community-based organizations that address heart and mental health disparities by December. We identified an opportunity to collaborate with the American Heart Association regarding providing support for moms and their babies. We are launching a release of New Mom kits that focus on monitoring mom and baby blood pressures as well as managing stress in the postpartum periods. Cardiovascular disease (heart disease and stroke) is the leading cause of death in women during and after pregnancy. “New Mom Kits” specifically designed to support new moms and their babies. The kits will encourage moms to learn about their own health and monitor their blood pressure during pregnancy and postpartum as well as learn CPR. We can help local moms and babies live longer, healthier lives. Kits will be mailed to one address and can be distributed locally. Each New Mom Kit includes:

- A blood-pressure (BP) cuff (model of BP cuff may vary)

- A booklet (in English and Spanish) with information on health during pregnancy and postpartum, plus resources to support the health of both mom and baby
- An Infant CPR Anytime kit that allows multiple caregivers to be trained in the lifesaving skill of CPR

With this initiative, it is our goal to ensure that every new mother has access to critical health resources and knowledge, empowering them to take charge of their well-being and that of their newborns. By partnering with the American Heart Association, we are leveraging their expertise to bring attention to the pressing issue of cardiovascular health in postpartum women, a crucial yet often overlooked aspect of maternal care. The New Mom Kits represent a comprehensive approach to health education, providing mothers with practical tools and information to monitor and manage their health effectively. This initiative not only aims to reduce the risk of heart disease and stroke among new mothers but also fosters a community of support by equipping families with CPR skills, ensuring they are prepared to act in emergencies.

As we distribute these kits, we are also gathering valuable feedback from recipients to continuously refine and enhance the resources we provide. This feedback loop is essential to our commitment to addressing health disparities and ensuring our interventions are culturally sensitive and responsive to community needs.
Through this program, we hope to set a precedent for collaborative health interventions, demonstrating the power of partnerships in creating sustainable health outcomes. Our vision is to expand this initiative beyond the initial distribution, reaching more communities and adapting the program to address a broader range of health challenges faced by mothers and infants.
Together, with our partners and community allies, we are dedicated to building a healthier future for mothers and their families, one where access to essential health resources is a right, not a privilege.

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. These trainings are 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 are offered live and on-demand throughout the tenure of ABH LA's relationship with TPN.health. For 2025, we anticipate offering 14 webinars/trainings, plus ODE. In addition to the upcoming live events, our provider network has access to our full on demand library.

Upcoming 2025 Webinars:

1. Perinatal Mental Health: Doulas Do It: Improving Perinatal Mental Health Through Sankofa: June 26th, 2025 11am-12:30pm EST
2. Combating Stigma: maternal health and SUD; signs/symptoms: peer to peer; referral resources
3. Tribal cultural competence
4. "Evidence-based practices, promising practices, emerging best practices"
5. Telehealth Practices
6. Integrating physical and behavioral health
7. Assessing and treating individuals with co-occurring I/DD
8. I/DD and dual diagnoses
9. Harm Reduction -extend 2023 webinar
10. MAT
11. Preventing/Reducing Exposure to ACEs (SHIP)
12. Reduce Barriers to BH Services (SHIP - State Health Improvement Plan)
13. PSS: Peer Support Specialists Services (SHIP) –(SHIP: training to increase our network of PSSs)
14. M-CHAT Training

2024 On Demand Education:

- ODE: The Value of Peers as Part of the Interdisciplinary Care Team
- ODE: Human Trafficking for Medical and Behavioral Health Providers | TPN.health
- ODE: Chronic Physical Health Conditions and Serious Mental Illness: | TPN.health
- ODE: Developing a Transgender-Culturally Fluent Praxis: | TPN.health
- ODE: A Fathers Presence: The Significant Impact Fathers Have on their Children's Well-Being | TPN.health
- ODE: Domestic Violence Dynamics: Trauma-Informed Screening with a Health Equity Focus | TPN.health
- ODE: Obesity and Mental Health in High Risk Communities | TPN.health
- ODE: Addressing Drivers of Inequities in Lactation Support | TPN.health
- ODE: Working with Patients Presenting with Suicidal Behaviors: | TPN.health
- ODE: Equity, Diversity, and Inclusion: Religion & Spirituality | TPN.health

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 ABHLA 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. In

addition to these courses, Health Equity 102: Social Determinants of Health, training course is now available to colleagues. The training introduces the concept of social determinants of health, including the various factors such as socioeconomic status, education and access to health care that significantly impact an individual's well-being.

Course Name	Course #	Course owner	Audience
Striving for Health Equity 101	374158918	Medicaid Clinical Learning & Performance	All Aetna Medicaid new hires
Aetna Better Health of Louisiana Cultural Competency Training	374100238	Medicaid Clinical Learning & Performance	ABHLA employees
Striving for Health Equity 102	551003	Medicaid Clinical Learning & Performance	All Aetna Medicaid staff

Advancing health equity is not a series of programs or training courses. It's our way of doing business. That means integrating health equity principles into how you engage with other colleagues, how policies and programs are designed and implemented, and how the company works with communities.

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, and these groups provide a platform for networking, mentoring, and advocacy. By fostering an inclusive culture, ABHLA aims to empower every team member to contribute to the organization's goals and create a supportive environment where diverse perspectives are valued and celebrated. In addition, ABHLA is committed to community outreach and collaboration with local organizations to further enhance health equity and accessibility. Through partnerships and initiatives, ABHLA seeks to address social determinants of health, ensuring that underserved populations receive the necessary support and resources. By integrating these strategies, ABHLA not only strengthens its provider network but also reinforces its dedication to equitable healthcare for all, paving the way for a healthier, more inclusive future.

Stratify MCO Results on Attachment H Measures

3. Stratified results for measures CY2024 (Measure #57)

Stratifying HEDIS measures by race and ethnicity allows us to identify care gaps and promote health equity. Our national Quality Management informatics team provides us with updated HEDIS reports. By leveraging this data, we can track our progress in addressing disparities and make informed decisions regarding resource allocation to enhance health outcomes for all members. By staying informed and proactive in our healthcare strategies, ABHLA can positively impact our community's well-being and work towards a future where everyone has equitable access to quality care.

1. **Pregnancy:**

PPC Timeliness of Prenatal Care

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator by Medical Records	Numerator By Supplemental	Rate
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Total	2,163	2,163	1,662	0	7	77.16%
	Race						
	White	822	822	643	0	4	78.71%
	Black or African American	1,062	1,062	810	0	3	76.55%
	American Indian and Alaska Native	31	31	21	0	0	67.74%
	Asian	32	32	24	0	0	75.00%
	Native Hawaiian or Other Pacific Islander	2	2	1	0	0	50.00%
	Some Other Race	74	74	54	0	0	72.97%
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	140	140	109	0	0	77.86%
	Ethnicity						
	Hispanic or Latino	717	717	543	0	2	76.01%
	Not Hispanic or Latino	1,237	1,237	973	0	5	79.06%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	209	209	146	0	0	69.86%
	Sex						
	Male	0	0	0	0	0	#DIV/0!
	Female	2,163	2,163	1,662	0	7	77.16%
	Unknown	0	0	0	0	0	#DIV/0!
	Geography						
	Rural	448	448	344	0	1	77.01%
	Urban	1,690	1,690	1,300	0	6	77.28%
	Unknown	25	25	18	0	0	72.00%
Validation Check	Total Race	2,163	2,163	1,662	0	7	
	Total Ethnicity	2,163	2,163	1,662	0	7	
	Total Sex	2,163	2,163	1,662	0	7	
	Total Geography	2,163	2,163	1,662	0	7	

PPC Postpartum Care

	Category	Eligible Population	Denominator	Numerator By Admin		Numerator By Supplemental	Rate
Prenatal and Postpartum Care: Postpartum Care	Total	2,163	2,163	1,526		29	71.89%
	Race						
	White	822	822	571		15	71.29%
	Black or African American	1,062	1,062	743		12	71.09%
	American Indian and Alaska Native	31	31	22		1	74.19%
	Asian	32	32	28		0	87.50%
	Native Hawaiian or Other Pacific Islander	2	2	2		0	100.00%
	Some Other Race	74	74	52		0	70.27%
	Two or More Races	0	0	0		0	#DIV/0!
	Asked but No Answer	0	0	0		0	#DIV/0!
	Unknown	140	140	108		1	77.86%
	Ethnicity						
	Hispanic or Latino	717	717	503		4	70.71%
	Not Hispanic or Latino	1,237	1,237	863		20	71.38%
	Declined Ethnicity	0	0	0		0	#DIV/0!
	Unknown Ethnicity	209	209	160		5	78.95%
	Sex						
	Male	0	0	0		0	#DIV/0!
	Female	2,163	2,163	1,526		29	71.89%
	Unknown	0	0	0		0	#DIV/0!
	Geography						
	Rural	448	448	308		14	71.88%
	Urban	1,690	1,690	1,203		14	72.01%
	Unknown	25	25	15		1	64.00%
Validation Check	Total Race	2,163	2,163	1,526	0	29	
	Total Ethnicity	2,163	2,163	1,526	0	29	
	Total Sex	2,163	2,163	1,526	0	29	
	Total Geography	2,163	2,163	1,526	0	29	

Low-Risk Cesarean Delivery

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Low-Risk Cesarean Delivery	Total	640	640	0	164	25.63%
	Race					
	White	253	253	0	72	28.46%
	Black or African American	253	253	0	66	26.09%
	American Indian and Alaska Native	9	9	0	3	33.33%
	Asian	7	7	0	2	28.57%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	62	62	0	10	16.13%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	56	56	0	11	19.64%
	Ethnicity					
	Hispanic or Latino	268	268	0	57	21.27%
	Not Hispanic or Latino	279	279	0	81	29.03%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	93	93	0	26	27.96%
	Geography					
	Rural	135	135	0	37	27.41%
	Urban	502	502	0	125	24.90%
	Unknown	3	3	0	2	66.67%
Validation Check	Total Race	640	640	0	164	
	Total Ethnicity	640	640	0	164	
	Total Geography	640	640	0	164	

2. **Child:**

Well Child Visits 1st 15 months

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Well-Child Visits in the First 30 Months of Life: First 15 Months	Total	1,947	1,947	1,243	59	66.87%
	Race					
	White	579	579	387	19	70.12%
	Black or African American	765	765	460	21	62.88%
	American Indian and Alaska Native	3	3	3	0	100.00%
	Asian	31	31	25	2	87.10%
	Native Hawaiian or Other Pacific Islander	1	1	1	0	100.00%
	Some Other Race	193	193	129	0	66.84%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	375	375	238	17	68.00%
	Ethnicity					
	Hispanic or Latino	304	304	172	9	59.54%
	Not Hispanic or Latino	992	992	646	23	67.44%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	651	651	425	27	69.43%
	Sex					
	Male	981	981	631	23	66.67%
	Female	966	966	612	36	67.08%
	Unknown					#DIV/0!
	Geography					
	Rural	405	405	240	17	63.46%
	Urban	1,530	1,530	995	42	67.78%
	Unknown	12	12	8	0	66.67%
Validation Check	Total Race	1,947	1,947	1,243	59	
	Total Ethnicity	1,947	1,947	1,243	59	
	Total Sex	1,947	1,947	1,243	59	
	Total Geography	1,947	1,947	1,243	59	

Well Child Visits 15 months – 30 months

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Well-Child Visits in the First 30 Months of Life: 15 Months - 30 Months	Total	1,611	1,611	1,100	45	71.07%
	Race					
	White	472	472	328	16	72.88%
	Black or African American	691	691	461	17	69.18%
	American Indian and Alaska Native	5	5	3	0	60.00%
	Asian	25	25	16	1	68.00%
	Native Hawaiian or Other Pacific Islander	2	2	1	0	50.00%
	Some Other Race	153	153	114	5	77.78%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	263	263	177	6	69.58%
	Ethnicity					
	Hispanic or Latino	292	292	182	7	64.73%
	Not Hispanic or Latino	944	944	653	29	72.25%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	375	375	265	9	73.07%
	Sex					
	Male	800	800	539	23	70.25%
	Female	811	811	561	22	71.89%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	298	298	188	9	66.11%
	Urban	1,298	1,298	904	35	72.34%
	Unknown	15	15	8	1	60.00%
Validation Check	Total Race	1,611	1,611	1,100	45	
	Total Ethnicity	1,611	1,611	1,100	45	
	Total Sex	1,611	1,611	1,100	45	
	Total Geography	1,611	1,611	1,100	45	

3. **Adult:**

HIV Viral Load

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
HIV Viral Load Suppression	Total	374	374	337	0	90.11%
	Race					
	White	55	55	48	0	87.27%
	Black or African American	151	151	143	0	94.70%
	American Indian and Alaska Native	4	4	4	0	100.00%
	Asian	20	20	20	0	100.00%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	0	0	0	0	#DIV/0!
	Two or More Races	2	2	2	0	100.00%
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	142	142	120	0	84.51%
	Ethnicity					
	Hispanic or Latino	39	39	36	0	92.31%
	Not Hispanic or Latino	301	301	273	0	90.70%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	34	34	28	0	82.35%
	Sex					
	Male	267	267	239	0	89.51%
	Female	107	107	98	0	91.59%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	33	33	28	0	84.85%
	Urban	338	338	306	0	90.53%
	Unknown	3	3	3	0	100.00%
Validation Check	Total Race	374	374	337	0	
	Total Ethnicity	374	374	337	0	
	Total Sex	374	374	337	0	
	Total Geography	374	374	337	0	

4. **Behavioral Health:**

Follow-up after Hospitalization for Mental Illness (within 30 days)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Follow-Up After Hospitalization for Mental Illness (Within 30 Days)	Total	3,248	3,248	1,265	23	39.66%
	Race					
	White	1,653	1,653	654	15	40.47%
	Black or African American	1,323	1,323	493	6	37.72%
	American Indian and Alaska Native	28	28	13	0	46.43%
	Asian	24	24	16	0	66.67%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	105	105	52	0	49.52%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	115	115	37	2	33.91%
	Ethnicity					
	Hispanic or Latino	1,066	1,066	419	5	39.77%
	Not Hispanic or Latino	1,896	1,896	739	15	39.77%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	286	286	107	3	38.46%
	Sex					
	Male	1,792	1,792	627	4	35.21%
	Female	1,456	1,456	638	19	45.12%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	670	670	258	7	39.55%
	Urban	2,545	2,545	999	16	39.88%
	Unknown	33	33	8	0	24.24%
Validation Check	Total Race	3,248	3,248	1,265	23	
	Total Ethnicity	3,248	3,248	1,265	23	
	Total Sex	3,248	3,248	1,265	23	
	Total Geography	3,248	3,248	1,265	23	

IET Initiation

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Initiation and Engagement of Substance Use Disorder Treatment: Initiation of SUD Treatment	Total	4,934	4,934	2,457	576	61.47%
	Race					
	White	2,513	2,513	1,319	331	65.66%
	Black or African American	2,104	2,104	997	212	57.46%
	American Indian and Alaska Native	37	37	8	7	40.54%
	Asian	24	24	10	1	45.83%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	117	117	56	7	53.85%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	139	139	67	18	61.15%
	Ethnicity					
	Hispanic or Latino	1,289	1,289	659	127	60.98%
	Not Hispanic or Latino	3,398	3,398	1,668	421	61.48%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	247	247	130	28	63.97%
	Sex					
	Male	2,820	2,820	1,487	303	63.48%
	Female	2,114	2,114	970	273	58.80%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,060	1,060	550	97	61.04%
	Urban	3,851	3,851	1,892	478	61.54%
	Unknown	23	23	15	1	69.57%
Validation Check	Total Race	4,934	4,934	2,457	576	
	Total Ethnicity	4,934	4,934	2,457	576	
	Total Sex	4,934	4,934	2,457	576	
	Total Geography	4,934	4,934	2,457	576	

IET Engagement

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Initiation and Engagement of Substance Use Disorder Treatment: Engagement of SUD Treatment	Total	4,934	4,934	1,316	107	28.84%
	Race					
	White	2,513	2,513	785	72	34.10%
	Black or African American	2,104	2,104	475	29	23.95%
	American Indian and Alaska Native	37	37	5	0	13.51%
	Asian	24	24	3	0	12.50%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	117	117	16	3	16.24%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	139	139	32	3	25.18%
	Ethnicity					
	Hispanic or Latino	1,289	1,289	338	25	28.16%
	Not Hispanic or Latino	3,398	3,398	907	80	29.05%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	247	247	71	2	29.55%
	Sex					
	Male	2,820	2,820	839	53	31.63%
	Female	2,114	2,114	477	54	25.12%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,060	1,060	289	29	30.00%
	Urban	3,851	3,851	1,022	78	28.56%
	Unknown	23	23	5	0	21.74%
Validation Check	Total Race	4,934	4,934	1,316	107	
	Total Ethnicity	4,934	4,934	1,316	107	
	Total Sex	4,934	4,934	1,316	107	
	Total Geography	4,934	4,934	1,316	107	

4. Please share other comments/observations on your Health Equity progress since the submission of the MCO 3.0 Health Equity Plan:

- The measurable objective for Community & Enrollee Engagement for 2025 changed from "Create a Health Equity Focused Grant Initiative based on outcomes of year 1 assessment" to "Create a Health Equity focused community initiative based on outcomes of year 2024 assessment" Due to unforeseen budget constraints, we are unable to directly create a health equity focused grant. However, we are able to create a community based initiative that will yield positive contributions to our overall goal of addressing health inequities specific to the local community.
- The measurable objective for Mental Health and Behavioral Health Services for 2025 changed from "Based on year 1 data and feedback, expand the scope of Telehealth services, solidify partnerships with rural CBOs, and implement a targeted initiative to address specific BH needs by December 2025" to "Solidify partnerships with rural CBOs, and implement a targeted initiative to address specific BH needs by December 2025; Our focus and needs have since changed since these goals were first written in 2023. Our BH telehealth programs are offered to our members in all 9 regions. At this time, we are in final contract stages of on-boarding a new BH telehealth vendor, Mindoula. We will have this new vendor set up by December 2025. Feedback received from community workgroups and CHCs has identified a need for ABHLA to strengthen our CBO partners and create targeted initiatives to address rural communities and their needs. We are heavily focused on this objective for 2025.